Medicare Health Outcomes Survey

Request for Use of the Questionnaire

Overview

The following Medicare HOS Instruments are available for use with permission:

- Medicare Health Outcomes Survey Instrument Version 3.0
- Medicare Health Outcomes Survey Instrument Version 2.5
- Medicare Health Outcomes Survey Instrument Version 2.0
- Medicare Health Outcomes Survey Instrument Version 1.0

Copies of the HOS 3.0, 2.5, 2.0 and 1.0 questionnaires are available for download from the Survey Instrument section of the HOS web site at http://hosonline.org/en/survey-instrument/. Please see the instructions below to request use of the HOS questionnaire.

Instructions to Request Use of the Questionnaire

1. **Survey Use Form:** Complete and sign the Medicare Health Outcomes Survey Use Form to request to use the questionnaire.

2. **Terms of Use Agreement**: Read and sign the Terms of Use agreement for the Medicare Health Outcomes Survey. By using the Survey, you and your organization agree to the stated terms and conditions (the Terms of Use). CMS reserves the right, at our discretion, to change any of these terms in the future. If you do not agree to these Terms of Use, you may not use the Survey.

3. **Survey Instrument:** Provide a sample copy of the proposed questionnaire including the appropriate copyright for the Medicare Health Outcomes Survey as indicated in the Terms of Use Agreement.

4. **Submit Survey Use Form, Terms of Use Agreement, and Proposed Survey Instrument to:**
   Ashley Darin
   Medicare Health Outcomes Survey, Project Manager
   NCQA
   1100 13th St NW, Suite 1000
   Washington DC 20005
   HOS@ncqa.org

   All requests are subject to approval by NCQA and CMS. Notification will be sent via e-mail within 10 business days.

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1. ORGANIZATION/CONTACT INFORMATION		
1a. ORGANIZATION NAME		
1b. MEDICARE CONTRACT NUMBER (if applicable)		
1c. PRIMARY CONTACT PERSON FIRST NAME	MIDDLE INITIAL	LAST NAME
1d. TITLE		
1f. MAILING ADDRESS I		
1g. MAILING ADDRESS 2		
1h. CITY	1i. STATE	1j. ZIP CODE
1k. TELEPHONE *(Area code, number, and extension)*		
1l. E-MAIL ADDRESS		
1m. FAX *(Area code and number)*		
1n. ORGANIZATION TYPE ☐ HMO ☐ PPO ☐ Disease Management ☐ Academic Institution ☐ Government (Specify Agency)		
☐ Other (Specify)		

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2. PROJECT INFORMATION

2a. PROJECT TITLE

2b. PROJECT TYPE

☐ Quality Improvement
☐ Clinical Projects
☐ Research
☐ Other (Specify)

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2c. PROJECT TIMING
Project Start & End Date:

2d. PROJECT DESCRIPTION: Briefly describe 1) purpose of project; 2) population you will be surveying; 3) how you are selecting the sample to be surveyed; and 4) the analyses that will be conducted. Attach additional sheets, if necessary.

3. QUESTIONNAIRE INFORMATION (Include Sample Questionnaire with Form)

3a. Version of HOS Questionnaire Requested:

3b. Items Used in Questionnaire

☐ Complete Questionnaire
☐ Subset of Questionnaire (Specify Survey Questions)

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4. APPLICANT ORGANIZATION SUBMISSION

Please complete and date the form.

I hereby attest that the information contained in this form is accurate to the best of my knowledge, and I agree that the Medicare Health Outcomes Survey will be used solely for the purpose specified in this Survey Use Form.

Authorized Representative

Name:

Title:

Organization:

Date:

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TO BE COMPLETED BY NCQA HOS STAFF
Documentation Provided: ☐ Survey Use Form ☐ Terms of Use Agreement ☐ Sample Questionnaire Request approval: ☐ Yes ☐ No
Comments:
Reviewer Name:
Title:
Date:

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