1100 13th Street NW, Third Floor
Washington, DC 20005
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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 website at http://hosonline.org/en/survey-instrument/.

See the instructions below to request use of the HOS questionnaire.

Instructions for Requesting Use of the Questionnaire

Survey Use Form: Complete and sign the Medicare HOS Use Form to request to use the questionnaire.

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.

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.

Submit the Survey Use Form, the Terms of Use Agreement and the Proposed Survey Instrument to:

Ashley Darin
Medicare Health Outcomes Survey Project Manager, NCQA
1100 13th St. NW, Third Floor Washington DC 20005
HOS@ncqa.org

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

Medicare HOS Use Form

1. Organization and Contact Information

1a. Organization Name

1b. Medicare Contract Number (if applicable)

1c. Primary Contact (first, middle initial, last)

1d. Primary Contact Title

1e. Organization Street Address

1f. City, State, Zip

1g. Organization Telephone Number (with extension)

1h. Organization Fax Number

1i. Organization Email Address

1j. Organization Type

☐ HMO
☐ PPO
☐ DMO
☐ Academic Institution
☐ Government Agency (specify)
☐ Other (specify)

2. Project Information

2a. Project Title

2b. Project Type ☐ Quality Improvement ☐ Clinical ☐ Research ☐ Other (specify)

2c. Project Start Date

2d. Project End Date

2e. Project Purpose

2f. Survey Population

2g. How Was the Survey Population Selected?

2h. What Analysis Will Be Conducted?

Attach additional sheets if necessary.

Medicare HOS Use Form

3. Questionnaire Information (include sample questionnaire with this form)

3a. Version of Questionnaire You Are Requesting

3b. Items Used in Questionnaire

☐ Complete Questionnaire

☐ Subset of Questionnaire (specify questions)

4. Applicant Organization Submission

Complete and date this 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

Authorized Representative Title

Organization

Date

Medicare HOS Use Form

To Be Completed by NCQA Staff

☐ Survey Use Form	☐ Terms of Use Agreement	☐ Sample Questionnaire
Request Approved?	☐ Yes	☐ No
Comments		
Reviewer Name		
Reviewer Title		
Date		