



Medicare Health Outcomes Survey Request for Use of the Questionnaire

Overview

The following Medicare HOS and HOS-M 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
- Medicare Health Outcomes Survey-Modified Instrument

Copies of the HOS 3.0, 2.5, 2.0 and 1.0 and HOS-M questionnaires are available for download from the Survey Instrument section of the [HOS website](http://hosonline.org/en/survey-instrument/) (<http://hosonline.org/en/survey-instrument/>).

Please see the instructions below to request use of the HOS or HOS-M 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 all or a subset of survey items.
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 HOS or HOS-M as indicated in the Terms of Use Agreement. If the questions will be administered verbally (in-person or over the phone), the applicant must provide a copy of the proposed script.
4. **Submit Survey Use Form, Terms of Use Agreement, and Proposed Survey Instrument electronically to HOS@ncqa.org or to:**

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

All requests are subject to approval by NCQA and CMS. Notification will be sent via e-mail within 10 business days. Approval expires after one year and organizations must reapply.

Medicare Health Outcomes Survey Use Form

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

1e. MAILING ADDRESS 1

1f. MAILING ADDRESS 2

1g. CITY

1h. STATE

1i. ZIP CODE

1j. TELEPHONE (*Area code, number, and extension*)

1k. EMAIL ADDRESS

1l. FAX (*Area code and number*)

1m. 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)

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 or HOS-M Requested:

3b. Items Used in Questionnaire
 Complete Questionnaire
 Subset of Questionnaire (Specify Survey Questions)

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 or Medicare Health Outcomes Survey-Modified will be used solely for the purpose specified in this Survey Use Form.

Authorized Representative

Name:

Title:

Organization:

Date:

Medicare Health Outcomes Survey Use Form

TO BE COMPLETED BY NCQA HOS STAFF

Documentation Provided:

- Survey Use Form
- Terms of Use Agreement
- Sample Questionnaire or Script

Request approval for one year:

- Yes
- No

Comments:

Reviewer Name:

Title:

Date:

Approval Expiration Date: