Medicare Health Outcomes Survey
Request for Use of the Questionnaire

Overview

The following Medicare HOS and HOS-M Instruments (Survey) 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/).

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 its 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 language 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. All applications must be typed and sent via email.**

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, annually.

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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 1		
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) ____
2c. PROJECT TIMING Project Start & End Date:
2d. PROJECT DESCRIPTION 1) Describe purpose of project:
2) Detail the population you will be surveying:
3) Describe how you are selecting the sample to be surveyed and the sample size:
4) Describe the analyses that will be conducted. Attach additional sheets, if necessary:

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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)

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4. SURVEY VENDOR INFORMATION (If Applicable)

4a. SURVEY VENDOR ORGANIZATION NAME

4b. PRIMARY CONTACT PERSON (FIRST NAME, LAST NAME, TITLE)

4c. PRIMARY CONTACT TELEPHONE NUMBER

4d. PRIMARY CONTACT EMAIL ADDRESS

5. 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:

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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:

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