Medicare Health Outcomes Survey
Survey Use Request Application

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 Application:** Complete and sign the Medicare Health Outcomes Survey Use Application to request to use all or a subset of survey items. You must provide a detailed description of the project. Incomplete applications will be returned to the requester for additional information and will delay review of your organization's request.

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 Application, Terms of Use Agreement, and Proposed Survey Instrument electronically to the HOS Project Team (HOS@ncqa.org). All applications must be typed and sent via e-mail.**

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.

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	STATE	ZIP CODE
1h. TELEPHONE *(Area code, number, and extension)*		
1i. E-MAIL ADDRESS		

1j. ORGANIZATION TYPE

- ☐ Health Plan
- ☐ Health Care Provider
- ☐ Academia
  - ☐ Researcher
  - ☐ Student
- ☐ Government (Specify Agency)
- ☐ Other (Specify)

2. PROJECT INFORMATION
2a. PROJECT TITLE
2b. PROJECT TYPE ☐ Quality Improvement ☐ Clinical Projects ☐ Research ☐ Other (Specify)
2c. PROJECT TIMING Project Start & End Date:
3. PROJECT DESCRIPTION
3a. Describe purpose of project:
3b. Detail the population you will be surveying:
3c. What is the sample size for your project? If fielding multiple surveys, list the sample size for each:
3d. Describe the sampling methodology (i.e., how will the survey sample be selected?). If fielding multiple surveys, describe the sampling methodology for each sample:
3e. When will the proposed survey be fielded? List month(s) and year:
3f. Describe the data collection method(s) and mode(s):

3g. Describe the analyses that will be conducted. Attach additional sheets, if necessary:

4. QUESTIONNAIRE INFORMATION (Include Sample Questionnaire with Application)
4a. Version of HOS or HOS-M Requested
4b. HOS or HOS-M Items Used in Proposed Survey Instrument ☐ Complete Questionnaire ☐ Subset of Questionnaire (Specify HOS or HOS-M Survey Questions) _____

5. SURVEY VENDOR INFORMATION (If Applicable)
5a. SURVEY VENDOR ORGANIZATION NAME
5b. PRIMARY CONTACT PERSON (FIRST NAME, LAST NAME, TITLE)
5c. PRIMARY CONTACT TELEPHONE NUMBER
5d. PRIMARY CONTACT EMAIL ADDRESS

6. APPLICANT ORGANIZATION SUBMISSION
Please complete and date the application. I hereby attest that the information contained in this application 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:

TO BE COMPLETED BY NCQA HOS STAFF
Documentation Provided: ☐ Survey Use Application ☐ Terms of Use Agreement ☐ Sample Questionnaire or Script Request approved for one year: ☒ Yes ☒ No
Comments:
Reviewer Name:
Title:
Date:
Approval Expiration Date: