HEDIS® Medicare Health Outcomes Survey Use Application

Overview

The following Medicare HOS and HOS-M Instruments (Surveys) are available for use with permission from NCQA:

- Medicare Health Outcomes Survey Instrument Version 3.0 – English, Spanish, Chinese, and Russian
- Medicare Health Outcomes Survey Instrument Version 2.5 – English
- Medicare Health Outcomes Survey Instrument Version 2.0 – English
- Medicare Health Outcomes Survey Instrument Version 1.0 – English
- Medicare Health Outcomes Survey-Modified Instrument – English, Spanish, Chinese, and Russian

Please see the instructions below to request use of the Surveys.

Instructions to Request Use of a Survey

1. **Survey Use Application:** Complete and sign this 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:** Read and sign the Terms of Use for the Surveys. If you do not agree to the Terms of Use, you may not use the Surveys.
   Survey vendors, health plans, or their agents are prohibited from administering any HOS and HOS-M survey questions to Medicare beneficiaries eight weeks before and during HOS and HOS-M administration.

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. 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, and the proposed survey instrument electronically to HOS@ncqa.org. All applications must be typed and sent via email.** All requests must be reviewed and approved by NCQA. Additional information may be requested if an application lacks sufficient detail. Applications will not be considered complete until all additional information is received. Requesting organizations will receive an approval decision within 10 business days of submitting a complete request. Approval expires one year after the approval date. Organizations may 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 ☐ Research ☐ Other (Specify) _____
2c. PROJECT TIMING (Project Start & End Date):
3. PROJECT DESCRIPTION
3a. Describe purpose of project:
3b. Describe the population to be surveyed:
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 select ed?). 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 your data collection method(s) and mode(s):

3. PROJECT DESCRIPTION (Continued)
3g. Describe the analyses that will be conducted. Attach additional sheets, if necessary:
4. QUESTIONNAIRE INFORMATION (Include Sample Questionnaire with Form)
4a. Version of HOS or HOS-M Requested:
4b. Items Used in Questionnaire: ☐ Complete Questionnaire ☐ Subset of Questionnaire (Specify Survey Questions) _____
5. SURVEY VENDOR INFORMATION (If Applicable)
SURVEY VENDOR ORGANIZATION NAME:
PRIMARY CONTACT PERSON (First Name, Last Name, Title):
PRIMARY CONTACT TELEPHONE NUMBER:
PRIMARY CONTACT EMAIL ADDRESS:
6. APPLICANT ORGANIZATION SUBMISSION
Please complete and date the form. 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 Application.
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: