

# CAHPS Hospice Survey

## Survey Vendor Authorization Form

Hospice agencies must authorize an approved CAHPS Hospice Survey vendor to submit data on their behalf for the administration of the CAHPS Hospice Survey.

**In order to authorize a survey vendor, a hospice representative must complete the CAHPS Hospice Survey Vendor Authorization Form and submit it to the RAND Corporation one calendar quarter (90 days) prior to the first time data will be submitted to the CAHPS Hospice Survey Data Warehouse.** The individual who completes this form for the hospice will be considered the CAHPS Hospice Survey Administrator for that hospice. Hospices should also designate, on the form, an individual within the hospice organization to serve as the main point of contact with the CAHPS Hospice Survey Project Team and to review data submissions by the survey vendor.

If your hospice is switching from one survey vendor to another, complete the Authorization Form for Changing Survey Vendors available on the project website, **not** this form.

This form must be signed and dated in the presence of a notary public, notarized and sent to the RAND Corporation. Please note, when completing the CAHPS Hospice Survey Vendor Authorization Form pertaining to multiple hospice agencies, it is appropriate to attach a list to the form (signed and dated by the CAHPS Hospice Survey Administrator) of all the hospices (hospice names and CMS Certification Numbers [CCNs]). Please check the box on the form indicating that a separate document is attached and indicate the number of hospice names or CCNs listed on the separate sheet.

If sent via U.S. Mail, send to:

RAND Corporation  
ATTN: Melissa A. Bradley  
CAHPS Hospice Survey  
1200 South Hayes Street  
Arlington, VA 22202

If sent via Federal Express, UPS or other overnight delivery service, send to:

RAND Corporation  
ATTN: Melissa A. Bradley  
CAHPS Hospice Survey  
1200 South Hayes Street  
Arlington, VA 22202  
Phone: 703-413-1100, extension 5599

*Note: After submission of the CAHPS Hospice Survey Vendor Authorization Form, no further action is required by the hospice to notify CMS of their survey vendor selection. The RAND Corporation communicates to CMS which hospice agencies have authorized a survey vendor to administer the CAHPS Hospice Survey on their behalf.*

# CAHPS Hospice Survey Vendor Authorization Form

I, \_\_\_\_\_ (print CAHPS Hospice Survey Administrator's name),  
acknowledge and accept the role and all of the responsibilities of the CAHPS Hospice Survey  
Administrator for \_\_\_\_\_ (print name of hospice),  
\_\_\_\_\_ (CMS Certification Number [CCN] or

CCN List is attached (indicate number of hospices on list \_\_\_\_\_)

Start Date for Survey Administration: \_\_\_\_\_

In this role I will be responsible for:

- 1) Authorizing a survey vendor to collect data for \_\_\_\_\_ (print name of hospice or "See attached document") as part of the CAHPS Hospice Survey and to submit data to CMS on behalf of the hospice.
- 2) Notifying CMS and the RAND Corporation immediately if the hospice de-authorizes a survey vendor by completing an Authorization Form for Changing Survey Vendors.
- 3) Designating an individual within the hospice organization to serve as the main point of contact with the CAHPS Hospice Survey Project Team and who will review data submissions by the survey vendor.
- 4) Notifying the CAHPS Hospice Survey Project Team if my role as the CAHPS Hospice Survey Administrator for the hospice will no longer be valid and identifying my successor.

By signing this form, I authorize \_\_\_\_\_ (print CAHPS Hospice Survey vendor name) to collect data for the hospice I represent as part of the CAHPS Hospice Survey and to submit data to CMS on behalf of the hospice.

Hospice Administrator First and Last Name: \_\_\_\_\_

Hospice Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Hospice Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Hospice Point of Contact** for the CAHPS Hospice Survey Project Team:

First and Last Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

**Name of Survey Vendor Authorizing:** \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

Stamp: \_\_\_\_\_

Notary Public Date: \_\_\_\_\_