OMB #: 0938-1066

Expires MONTH DAY, YEAR

Home Health Care CAHPS® Survey

20XX

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1066. This information collection produces comparable data from home health agencies to help individuals choose an agency and improve care. The time required to complete this information collection is estimated to average less than 9 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory for qualifying home health agencies under 42 CFR §484.255(i) to meet program requirements and voluntary for survey respondents. Confidentiality is assured under 5 U.S.C. 552a (Privacy Act of 1974). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports ClearanceOfficer, Mail Stop C1-25-05, Baltimore, Maryland 21244-1850.  **\*\*\*\*CMS Disclosure\*\*\*\***  **Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your survey, please email** HomeHealthCAHPS@cms.hhs.gov**.**

Survey Instructions

* Answer all the questions by checking the box to the left of your answer.
* **If you are answering for someone who received home health care**, please try to answer questions from his or her point of view.
* Sometimes you can skip some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

 Yes

 No  **If No, skip to Q1.**

Your Home Health Care

1. According to our records, you got care from the home health agency, **[AGENCY NAME]**. Is that right?

1 Yes

2 No  **If No, please stop and return the survey in the envelope provided.**

Your Care from Home Health Staff

These next questions are about all the different staff from **[AGENCY NAME]**. Do not include care you got from staff from another home health care agency.

1. When you first started getting home health care from this agency, did someone from the agency talk about **ways to help make your home safer**? For example, they may have suggested adding grab bars in the shower or removing tripping hazards.

1 Yes

2 No

3 I don’t know

4 I did not need help with home safety

1. Has someone from the agency ever **reviewed the prescribed and over-the-counter medicines** you were taking? For example, they might have asked you to show them your medicines and talked with you about how and when to take each one.

1 Yes

2 No

3 I don’t know

4 I don’t take any medicines

1. In the last 2 months of care, did home health staff from this agency talk with you about any **side effects** of your medicines?

1 Yes

2 No

3 I don’t know

4 I don’t take any medicines

1. In the last 2 months of care, how often did home health staff from this agency keep you informed about **when they would arrive** at your home?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did home health staff from this agency seem to be **aware of all the care or treatment** you were getting at home?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did home health staff from this agency **treat you with care** – for example, when moving you around or changing a bandage?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did home health staff from this agency **explain things** in a way that was easy to understand?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did home health staff from this agency **listen carefully** to you?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did home health staff from this agency treat you with **courtesy and respect**?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, how often did you feel that home health staff from the agency **cared about you as a person**?

1 Never

2 Sometimes

3 Usually

4 Always

1. In the last 2 months of care, did home health staff from this agency **provide your family or friends with** **information or instructions** about your care as much as you wanted?

1 Yes

2 No

3 I don’t know

4 I did not want or need this

1. In the last 2 months of care, how often have the services you received from this agency **helped you take care of your health**?

1 Never

2 Sometimes

3 Usually

4 Always

1. We want to know your rating of your care from this agency’s home health staff.

Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to **rate your care** from this agency’s home health staff?

 0 Worst home health care possible

 1

 2

 3

 4

 5

 6

 7

 8

 9

 10 Best home health care possible

Your Home Health Agency

The next questions are about the office of **[AGENCY NAME]**.

1. Have you contacted this agency’s **office** for help or advice?

1 Yes

2 No  **If No, skip to Q17.**

1. When you contacted this agency’s office, did you get the help or advice you needed?

1 Yes

2 No

1. Would you recommend this agency to your family or friends if they needed home health care?

1 Definitely no

2 Probably no

3 Probably yes

4 Definitely yes

About You

There are only a few questions left.

**If you are answering on behalf of a family member or friend who received home health care:** these questions are about that person, not yourself.

1. In general, how would you rate your overall health?

1 Excellent

2 Very good

3 Good

4 Fair

5 Poor

1. In general, how would you rate your overall mental or emotional health?

1 Excellent

2 Very good

3 Good

4 Fair

5 Poor

1. Do you live alone?

1 Yes

2 No

1. What is the highest grade or level of school that you have completed?

1 8th grade or less

2 Some high school, but did not graduate

3 High school graduate or GED

4 Some college or 2-year degree

5 4-year college graduate

6 More than 4-year college degree

1. What is your race or ethnicity? Please mark one or more.
2. American Indian or Alaska Native
3. Asian
4. Black or African American
5. Hispanic or Latino
6. Middle Eastern or North African
7. Native Hawaiian or Pacific Islander
8. White
9. What language do you mainly speak at home?

1 English

2 Spanish

3 Some other language: *(Please print.)*

1. Did someone help you complete this survey?

1 Yes

2 No  **If No, please return your completed survey in the postage-paid envelope.**

1. How did that person help you? Check all that apply.

1 Read the questions to me

2 Wrote down the answers I gave

3 Answered the questions for me

4 Translated the questions into my language

5 Helped in some other way: *(Please print.)*

6 No one helped me complete this survey

**Thank you!**

**Please return the completed survey
in the postage-paid envelope.**