ATTACHMENT 6: BENEFICIARY SATISFACTION SURVEY MATERIALS IN ENGLISH

Attachment 6.a. Pre-Notification Letter (English)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S1-13-05
Baltimore, Maryland 21244-1850

Month 2014

NAME
ADDRESS
CITY, STATE ZIP

Dear NAME:

The Centers for Medicare & Medicaid Services (CMS), a federal government agency, is doing a survey with people who took part in special programs just for people with Medicaid. This survey is called the **Program Participant Survey**. Your name was chosen at random from a list of people who were in one of these special programs. In the next few days you will get a survey in the mail asking about your experiences with the **(Program Name or Specific Program Name) program**.

It is your choice whether or not to do the survey. Your decision will not affect your Medicaid benefits. Your answers will be kept confidential and are protected by the Privacy Act. We will not share your answers with [program name]. We hope that you will do the survey. Your answers will help us to make programs like this better.

If you have any questions, please call NAME toll-free at 1-877-XXX-XXXX. Si desea recibir la versión de la encuesta en español, por favor llame al 1-877- XXX-XXXX.

Thank you for your help with this survey.

Sincerely,

NAME
CMS TITLE