

**Attachment 6.a. Pre-Notification Letter**

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



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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