

Attachment 6.b. Survey Cover 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:

About a week ago, we sent you a letter about a survey that the Centers for Medicare & Medicaid Services (CMS) is doing called the **Program Participant Survey**. That survey is included with this letter.

Your name was chosen at random from a list of people who were in the **(Program Name or Specific Program Name) program**. The survey has questions about your experiences with the **(Program Name or Specific Program Name) program**. Please take a few minutes to answer the survey. Please return the survey in the envelope included with this letter.

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 or Specific 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