**MEDICARE CURRENT BENEFICIARY SURVEY**

**RESIDENT CONSENT FORM**

You have been selected to participate in the Medicare Current Beneficiary Survey (MCBS). The purpose of this survey is to collect information about the use of health services and costs associated with those services, health status, and insurance coverage of sample members who are or were receiving Medicare benefits. The survey is sponsored by Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services that oversees the Medicare Program.

The information collected for MCBS will be held in strict confidence by Westat, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study, and will not be disclosed or released to anyone except those involved in research without the consent of the individual or the establishment in accordance with the Privacy Act of 1974 (Public Law 93-579).

Data will be collected from your medical records and through interviews with designated "responsible persons." Participation in the study is voluntary. Refusal to participate or continue participation will involve no penalty or loss of benefits to which you are otherwise entitled.

Your participation is very important for assuring that survey information is complete and accurate, and we hope you will agree to participate.

**********

I have read the above statement and have had my questions answered to my satisfaction. I agree to participate in the Medicare Current Beneficiary Survey.

_____
Name (Please Print)

_____
Signature

_____
Date

| | |
|---|---|
| FOR OFFICE USE ONLY<br>SP ID:_____ | FACILITY ID:_____ |

**MEDICARE CURRENT BENEFICIARY SURVEY**

**NEXT OF KIN CONSENT FORM**

_____ has been selected to participate in the Medicare Current
**Name of Sampled Person**
Beneficiary Survey (MCBS). The purpose of this survey is to collect information about the use of health services and costs associated with those services, health status, and insurance coverage of sample members who are or were receiving Medicare benefits. The survey is sponsored by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services that oversees the Medicare Program.

Information collected for the MCBS will be held in strict confidence by Westat, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study, and will not be disclosed or released to anyone except those involved in research without the consent of the individual or the establishment in accordance with the Privacy Act of 1974 (Public Law 93-579).

Data will be collected from medical records and through interviews with relatives or designated "responsible persons." Participation in the study is voluntary. Refusal to participate or continue participation will involve no penalty or loss of benefits to which _____
is otherwise entitled. **Sampled Person**

Your participation is very important for assuring that survey information is complete and accurate, and we hope you will agree to participate.

**********

I have read the above statement and have had my questions answered to my satisfaction. I give my consent for participation in the Medicare Current Beneficiary Survey.

_____
Name (Please Print)

_____
Signature

_____
Relationship to Sampled Person

_____
Date

| | |
|---|---|
| FOR OFFICE USE ONLY<br>SP ID:_____ | |