MEDICARE CURRENT BENEFICIARY SURVEY
NEXT OF KIN CONSENT FORM

_____ has been selected to participate in the Medicare Current
Name of Respondent
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 & 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 protected by NORC at the University of Chicago, the contractor collecting the data, and by CMS. It will be used only for the purposes stated for this study. Identifiable information will not be disclosed or released to anyone except those involved in research without the consent of the individual or the establishment except as required under 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.
Name of Respondent

Your participation is very important for ensuring 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.

FOR INTERVIEWER USE ONLY

RESPONDENT ID:

_____

_____
Name (Please Print)

_____
Signature

_____
Relationship to Respondent

_____
Date

OMB No. 0938-0568 | Expires 8/31/2022

MCBS
Medicare Current Beneficiary Survey