Breakthrough Award Submission Form

Patient Experience [ ED CAHPS, CG-CAHPS, OAS, & HH CAHPS ]

* Please enter your Top Box Percentages as outlined in the form below.
* Each score will need to be validated by your Survey Vendor Report.
* Vendor reports must have the scores either highlighted or circled when submitted.

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| --- | --- | --- | --- |
| **DOMAIN** | **Your Top Box Percentage**  ***July 2020 – June 2021***  *(Rolling Year to Date/Average)* | **Your Top Box Percentage**  ***July 2021 – June 2022***  *(Rolling Year to Date/Average)* | **Top Box Percentage**  **National Average**  ***July 2021 – June 2022*** |
| **ED CAHPS** | | | |
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| **CG-CAHPS** | | | |
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| **OAS CAHPS** | | | |
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| **HH CAHPS** | | | |
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**Submitted by:**

Organization:

Contact Person:  Title:

Phone:

Email:

**Validated by:** (Attach a copy of your survey vendor’s report for each submission)

Survey Vendor:

Contact Person:  Title:

Phone:

Email: