Exhibit B

Member Information

State ID

Member Name:

Member DOB:

Aid Type: 501

Medically Exempt Member Survey

Compared to other people your age, how would you rate your health?

Compared to other people your age, how would you rate your mental health?

How often do you need help from another person in doing the activities below?

- Bathing
- Walking
- Transferring
- Eating
- Managing Your Medications

In the last six months, how many times have you stayed overnight as a patient in a hospital?

In the last six months, how many times have you used an emergency room?

In the last six months, how many times have you been seen by a doctor/nurse practitioner/physician assistant?
(Count office/clinic visits and home visits; Do not count emergency room or hospital visits)

If you use drugs or alcohol, how often does it keep you from doing your daily activities?

If you experience sadness, depression or nervousness, how often does it keep you from doing your daily activities?

Do you receive Social Security disability benefits?

Submit Cancel