Department of HUMAN SERVICES

{Current Date}

{Member Name}
{Address Line 1}{Address Line 2}
{City}, {State} {Zip}

Name: {Member Name} **Medicaid Member ID #** {State ID}

Please Answer the Following Questions and Return

You may have already been notified that you have been assigned to a Medicaid health plan. However, by answering the questions on the other side of this form you will help us ensure you are enrolled in the plan that best fits your medical needs. Your answers may lead to a change in your health plan assignment to better meet your medical needs.

Completing and returning this form is optional. If you choose to respond, please answer all of the questions on the other side in pencil or blue or black ink and return the form.

Three ways to return this form:

1. Use the enclosed postage paid envelope OR

2. Fax it to the Iowa Medicaid Enterprise at: 515-725-1351, OR

3. Call Iowa Medicaid Member Services at at **1-800-338-8366** or locally at 515-256-4606 to complete the survey over the phone.

Need help?
If you have any questions, please call Iowa Medicaid Member Services at **1-800-338-8366** or locally at 515-256-4606 between 8 a.m. and 5 p.m., Monday through Friday.

Si necesita informacion en espanol porfavor llamenos al servicio de miembros 1-800-338-8366.

Turn Page Over: Questions on the Back Page

Name: {Member Name} **Medicaid Member ID #** {State ID}

Please Answer the Following Questions and Return

Completing and returning this form is optional. If you choose to respond, please answer all of the questions below.

1. **Compared to other people your age, how would you rate your physical health?**

   ☐Excellent ☐Good ☐Fair ☐Poor

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

   ☐Excellent ☐Good ☐Fair ☐Poor

3. **How often do you need help from another person in doing activities like: bathing, walking, eating, managing your medications?**

   ☐Never ☐1-2 times a week ☐3-4 times a week ☐Every day

4. **Other than for pregnancy, in the last six months, how many times have you stayed overnight as a patient in a hospital?**

   ☐None ☐1 time ☐2 time ☐3 or more times

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

   ☐None ☐1 time ☐2 times ☐3 or more times

6. **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)?**

   ☐None ☐1-2 times ☐3-5 times ☐More than 5 times

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

   ☐Never ☐Sometimes ☐Often ☐Always

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

   ☐Never ☐Sometimes ☐Often ☐Always

9. **Do you receive Social Security disability benefits?**

   ☐Yes ☐No

Questions? Call Iowa Medicaid Member Services at 1-800-338-8366 or locally at 515-256-4606.