McLaren HEALTH PLAN

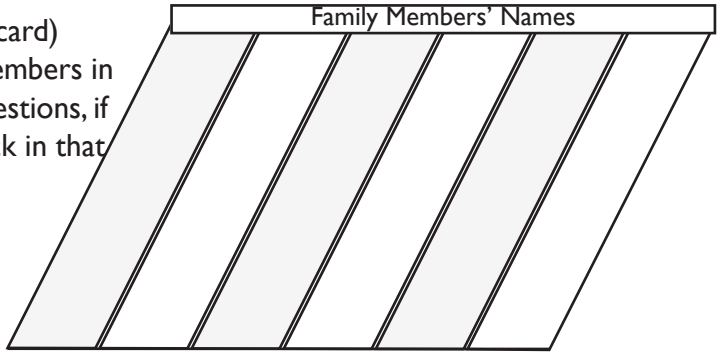
Staying In Touch Program
Welcome Survey

Welcome to McLaren Health Plan! The Staying In Touch program connects our members with their own personal nurse who will help you with all of your health care needs. By taking a moment to fill out and return this survey, your confidential responses will help us get **In Touch** with you and determine if you would benefit from this program.

The information provided in this survey is confidential and subject to your privacy rights!

Please fill in your name and contract number (found on your card) below. Also fill in your name and the names of your family members in the spaces provided to the right. As you read through the questions, if a condition affects you or a member of your family, put a check in that person's column so we know who has which condition.

(If there are more than six members in your family, please send back an additional page with the additional family members' information.)



Member Name: _____

Contract Number: _____

We want to make sure that all our members get the best care possible. Although you have the option not to answer questions about ethnicity or race, this information helps us review the treatment that members receive and make sure that everyone gets the highest quality of care. (You may select more than one option.)

Age?

Are you Spanish/Hispanic/Latino?

No:						
Yes:						
Don't know/Not sure:						
Refused:						

What is your race?

White:						
Black:						
American Indian or Alaska Native:						
Asian:						
Native Hawaiian or other Pacific Islander:						
Other:						

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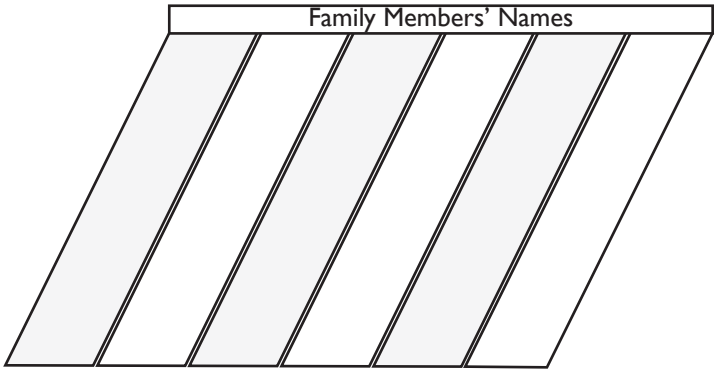

Personal Health History

1. How would you describe the general health of you and your family members?

Excellent:						
Good:						
Fair:						
Poor:						

2. Have you, or have your family members, had an annual physical exam in the last year?

Yes:						
No:						

3. Has a healthcare professional told you or any of your family members that you or they have any of these conditions?

If Yes, check box. If No, leave blank.

Heart Problems:						
High Blood Pressure:						
Asthma:						
Diabetes:						
Stomach Problems or Ulcers:						
Kidney Disease:						
Chronic Pain:						
Obesity:						
Depression:						
Other Health History:						

4. Please explain the current treatments for the conditions indicated above:

_____

_____

_____

5. Are you, or is anyone in your family, on three or more medications (prescription or over-the-counter)?

Yes:						
No:						

6. Please list the height and weight (lbs) for you and each of your family members:

Height:						
Weight:						

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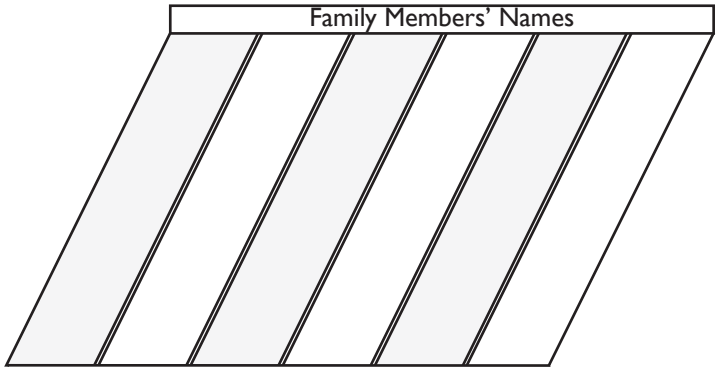

Special Needs

7. Do you, or does anyone in your family, have a vision impairment that requires special reading materials?

Yes: | | | | | | |
No: | | | | | | |

8. Do you, or does anyone in your family, have a hearing impairment that requires special equipment?

Yes: | | | | | | |
No: | | | | | | |

9. Is English your primary language? If not, what language do you prefer to speak?

Yes: | | | | | | |
No: | | | | | | |

Healthy Lifestyles

10. Do you and your family eat a healthy diet that includes whole grain bread, pasta, beans, nuts, fruits, vegetables, and lean meats every day?

Yes: | | | | | | |
No: | | | | | | |

11. Do you and your family members regularly participate in any physical activity or exercise? (Ex: running, golf, calisthenics, gardening, etc.)

Yes: | | | | | | |
No: | | | | | | |

12. Women's Health

a) Have you had a PAP test (to detect cervical cancer) within the last year?

b) Have you had a mammogram (to detect breast cancer) within the last year?

c) Are you currently pregnant?

Yes: | | | | | | |
No: | | | | | | |
Yes: | | | | | | |
No: | | | | | | |
Yes: | | | | | | |
No: | | | | | | |

13. Have you, or has someone in your family, had a flu shot in the last 12 months?

Yes: | | | | | | |
No: | | | | | | |

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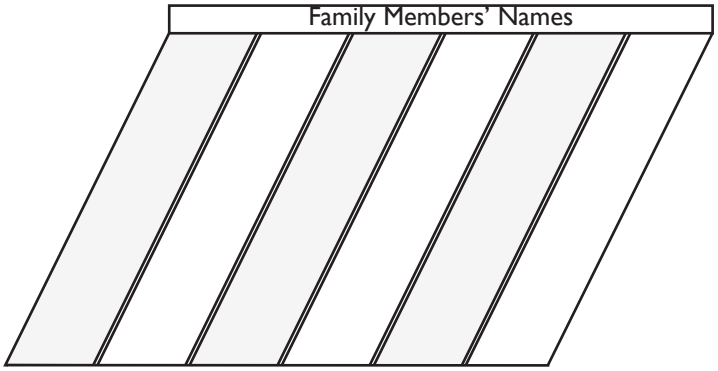

14. Do you, or does someone in your family, smoke pipes, cigars, cigarettes or chew tobacco?

15. Do you, or does someone in your family, exhibit behaviors that suggest that you or they have trouble with alcohol?

16. Have you, or has someone in your family, ever had a blood stool test, colonoscopy, or sigmoidoscopy?

17. Have you, or has someone in your family, suffered a personal loss or misfortune in the past 12 months? (Ex: job loss, divorce/separation, legal issues, disability, domestic violence, etc.)

18. In the past month have you, or someone in your family, been bothered by feeling down or hopeless?

19. During the past month, has stress had a major effect on your health?

20. Do you often miss work due to personal or family health issues?

21. Have you, or has anyone in your family, been hospitalized in the last year? If yes, please explain:

22. Have you, or has anyone in your family, gone to the Emergency Room more than once in the last year? If yes, please explain:

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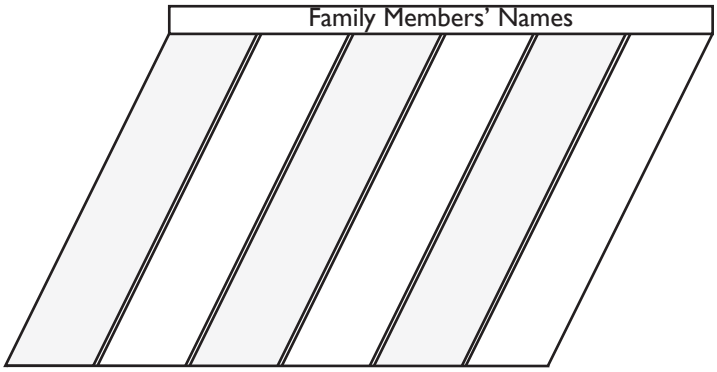

Healthy Goals

23. Are you, or is someone in your family, interested in setting health goals for activity, eating, weight loss, smoking, or other health goals?

Yes:						
No:						

24. Indicate your readiness, or someone in your family's readiness, for making changes or improvements in lifestyle behaviors:

(5 = Very ready to change... 1 = Not ready to change)

5:						
4:						
3:						
2:						
1:						

25. Lifestyle behavior that I, or family members , want to change: _____

_____

_____

_____

26. A customer service representative or a member of our medical management team is available to help with any questions or concerns regarding your coverage. Would you like us to contact you?

Yes:						
No:						

McLaren Health Plan encourages you to complete this health appraisal annually!

If you would like a copy of the Staying In Touch Survey, you can find it in the Members section of our website at McLarenHealthPlan.org or call our Customer Service Team at (888) 327-0671 and they will mail you a copy.

If have any questions regarding this survey or your health plan, please contact Customer Service at (888) 327-0671.

Please return the completed survey in the included postage-paid envelope or mail to:
McLaren Health Plan
P.O. Box 1511
Flint, MI 48501-1511