

P.O. Box 237 Cincinnati, Ohio 45201-0237 Telephone: (800) 366-6654

## Senior Supplement Full Name (first, middle initial, last) With whom do you reside? Are you a recipient of state Medicaid or other similar program benefits? Yes No Do you require assistance of any kind in performing the following activities? Cleaning and bathing yourself ☐ Yes ☐ No Dressing yourself ☐ Yes ☐ No ☐ Yes ☐ No Feeding yourself ☐ Yes ☐ No Going to the toilet ☐ Yes ☐ No ☐ Yes ☐ No Getting in and out of bed Walking ☐ Yes ☐ No Housekeeping ☐ Yes ☐ No Shopping ☐ Yes ☐ No ☐ Yes ☐ No Cooking Doing laundry ☐ Yes ☐ No ☐ Yes ☐ No Using Transportation Balancing your checkbook ☐ Yes ☐ No ☐ Yes ☐ No Using the telephone Taking medicine 5. Do you take part in activities outside the home such as golf, bridge, bowling, club meetings, theater, travel, etc.? ☐ Yes ☐ No Describe activities and how often you participate: ☐ Yes ☐ No Do you have a valid driver's license? Do you drive? ☐ Yes ☐ No How many miles do you drive per year? Have you, in the last 2 years, suffered any injuries as the result of a fall? $\square$ Yes $\square$ No If Yes, please provide details: Agreement The statements and answers shown on this questionnaire are true and complete to the best of my knowledge and belief. Applicant Signature Date Witness Signature Date

Form 3113 6/16 Page 1 of 1