

Attachment I.G.8-1 Medicaid Enrollee Needs Assessment (Kentucky SKY)

| | | | |
|--|------------|--|--|
| Que_09003 Equals Several days AND Que_09004 Equals Nearly everyday | Que_999163 | | |
| Que_09003 Equals Nearly everyday AND Que_09004 Equals Several days | Que_999163 | | |
| Que_09003 Equals More than half the days AND Que_09004 Equals More than half the days | Que_999163 | | |
| Que_09003 Equals More than half the days AND Que_09004 Equals Nearly everyday | Que_999163 | | |
| Que_09003 Equals Nearly everyday AND Que_09004 Equals More than half the days | Que_999163 | | |
| Que_09003 Equals Nearly everyday AND Que_09004 Equals More than half the days | Que_999163 | | |
| Que_999213 NotEquals None | Que_999214 | | |
| Que_999009 Equals None | Que_999010 | | |
| Que_999078 Equals Yes | Que_999079 | | |