Program Name

Program Information Cover Sheet

Instructions to Program Facilitator(s): Please provide the requested details about this program. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the Survey Coordinator.

1. 3	Site Name: Address:					
(City:		State:	_ Zip:		
 Program Facilitator Names (please provide full first and last names and provide the daytime phone number and/or email of the best person to contact about any questions on the forms) 						
Ī	First Name	Last Name	Email: Would you lik	 e to receive program information from the ME Resource Center? ☐ Yes ☐ No		
Ī	First Name	Last Name	Email: Would you lik	 e to receive program information from ME Resource Center? ☐ Yes ☐ No		

პ.	PI	End Date (mm/dd/yyyy)://		
4.		d you offer a "Session 0" with this program? (Session 0 is an optional pre-program ssion. Not all programs offer a Session 0.)		
	O	Yes		
	0	No		
	0	Don't know		
5.		hat type of program is this? Mark only one. [Note to grantee: adapt this section to fit cal programming]		
	O	Active Living Every Day		
	0	Arthritis Foundation Aquatic Program		
	0	Arthritis Foundation Exercise Program		
	0	BRI Care Consultation		
	0	Cancer: Thriving and Surviving		
	0	Chronic Disease Self-Management Program (CDSMP)		
	0	Chronic Pain Self-Management Program (CPSMP)		
	0	Diabetes Self-Management Program (DSMP)		
	0	Eat Smart, Move More, Weigh Less		
	0	EnhanceFitness		
	0	EnhanceWellness		
	0	Fit and Strong!		
	0	Geri-Fit		
	0	Health Coaches for Hypertension Control		
	0	Healthy IDEAS		
	0	Healthy Moves for Aging Well		
	0	HomeMeds		
	0	Living Well in the Community		
	0	On the Move		
	0	PEARLS		
	0	Positive Self-Management Program for HIV		
	0	Programa de Manejo Personal de la Diabetes (Spanish DSMP)		
	0	Screening, Brief Intervention, and Referral to Treatment (SBIRT)		
	0	Tomando Control de su Salud (Spanish CDSMP)		

O Walk With Ease

	U	Wellness Recovery Action Plan (WRAP)		
	0	Workplace Chronic Disease Self-Management Program (wCDSMP)		
6.	Ple	ease check which language you used when offering this program:		
	\circ	Facilish		
	O	English		
	O	Spanish		
	0	Other:		
7.	Wh	nat funding source(s) were used to support this program? Check all that apply.		
	_			
	O	ACL CDSME Grant		
	0	Older Americans Act (Title III-D, Title III-E, etc.)		
	0	Centers for Disease Control and Prevention		
	0	Other Federal Funding		
	0	Medicaid/Medicaid Waiver		
	0	Medicare/Medicare Advantage		
	0	Other Health Care Payer		
	0	Foundation Funding		
	0	Corporate Sponsor		
	0	Don't Know		
	0	Other:		

<u>Paperwork Reduction Act Public Burden Statement:</u>

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0036). Public reporting burden for this collection of information is estimated to average .33 hours per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority of Public Law 115-245.