

# Program Name

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## ***Program Information Cover Sheet***

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***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. Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. 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)

_____	_____	Ph: ( ) - _____
First Name	Last Name	Email: _____

Would you like to receive program information from the National CDSME Resource Center?

Yes     No

_____	_____	Ph: ( ) - _____
First Name	Last Name	Email: _____

Would you like to receive program information from the National CDSME Resource Center?

Yes     No

3. How old are you today? \_\_\_\_\_ years

4. Are you of Hispanic, Latino, or Spanish origin?     Yes     No

5. What is your race? **Check all that apply.**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Some other race (please specify) \_\_\_\_\_

6. Which option best describes your status as a program facilitator?
- Paid Staff member
  - Volunteer
  - Other
7. Program Start Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_
- End Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_\_
8. How was the program delivered?
- In-person
  - Online
  - Phone
  - Mail
  - Hybrid (please specify)\_\_\_\_\_
9. Did you offer a “Session 0” with this program? (Session 0 is an optional pre-program session. Not all programs offer a Session 0.)
- Yes
  - No
  - Don’t know
10. What type of program is this? Mark only one. [Note to grantee: adapt this section to fit local programming]
- Active Living Every Day
  - Arthritis Foundation Aquatic Program
  - Arthritis Foundation Exercise Program
  - BRI Care Consultation
  - Cancer: Thriving and Surviving
  - Chronic Disease Self-Management Program (CDSMP)
  - Chronic Pain Self-Management Program (CPSMP)
  - Diabetes Self-Management Program (DSMP)
  - Eat Smart, Move More, Weigh Less
  - Enhance Fitness
  - Enhance Wellness
  - Fit and Strong!
  - Geri-Fit
  - Health Coaches for Hypertension Control
  - Healthy IDEAS
  - Health Matters Program
  - Healthy Moves for Aging Well
  - HomeMeds
  - Live in Control (¡Sí, Yo Puedo Controlar Mí Diabetes!)
  - Living Well in the Community
  - Mind Over Matter
  - On the Move
  - PEARLS

- Positive Self-Management Program for HIV
- PREPARE for Your Care
- Programa de Manejo Personal de la Diabetes (Spanish DSMP)
- Respecting Choices
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Tomando Control de su Salud (Spanish CDSMP)
- Walk With Ease
- Wellness Recovery Action Plan (WRAP)
- Workplace Chronic Disease Self-Management Program (wCDSMP)

11. Please check which language you used when offering this program:

- English
- Spanish
- Other: \_\_\_\_\_

12. What funding source(s) were used in direct support of this program? Check all that apply.

- ACL CDSME Grant
- Older Americans Act (Title III-D, Title III-E, etc.)
- Centers for Disease Control and Prevention
- Other Federal Funding
- Medicaid/Medicaid Waiver
- Medicare/Medicare Advantage
- Other Health Care Payer
- Foundation Funding
- Corporate Sponsor
- Don't Know
- Other: \_\_\_\_\_

Public Burden Statement:

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