OMB Control No. 0985-0036
Exp. Date XX/XX/20XX

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. 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: _____