[Program Name] Participant Post Program Survey

<u>Admin Use Only</u>: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
<u>State abbreviation</u>: __ __ (e.g., NY, VA, etc.)
<u>First four letters of the site name</u>: __ __ __ __
<u>Start date of program</u>: __ __ / __ __ / __ __ (e.g., 12/01/19)
<u>Participant number</u>: __ __ (e.g., 01, 02, 03, etc.)

1. In general, would you say that your health is:

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How often do you feel lonely?

   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

3. How often do you feel isolated from those around you?

   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

4. Since this program began, how many times have you fallen? ____times ☐ None

   If you fell since the program began:

   a. how many of these falls caused an injury? *(Caused you to limit your regular activities for at least a day or to go see a doctor.)*

      _______number of falls causing an injury

   b. what happened after you fell? *(Please check all that apply)*

      ☐ Told a family member or friend ☐ Visited my Health Care Provider
      ☐ Went to an Urgent Care Center ☐ Went to the Emergency Room
      ☐ Was admitted to the hospital ☐ Did not seek medical care

5. Since this program began, has your concern about falling interfered with your normal social activities with family, friends, and neighbors (e.g., avoiding situations with stairs or uneven ground)?

   ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

6. How confident are you today that you can do the following activities **without falling**?

Activities	**Very Confident 1**	**Confident 2**	**Somewhat Confident 3**	**Fairly Confident 4**	**Not at all Confident 5**
Take a bath or shower					
Reach into cabinets or closets					
Walk around the house					
Prepare meals					
Get in and out of bed					
Answer the door or telephone					
Get in and out of a chair					
Getting dressed and undressed					
Personal grooming (i.e., washing your face)					
Getting on and off the toilet					
Total Score					

7. What best describes your physical activity level?
   - ☐ Vigorous-intensity activity at least 3 times per week (jogging, shoveling snow, fitness class)
   - ☐ Moderate-intensity activity at least 3 times per week (brisk walking, raking the yard)
   - ☐ Light-intensity activity (slow walk, cooking, light household chores)
   - ☐ Seldom active (preferring sedentary activity, such as watching TV)

8. Please use an **X** to tell us your thoughts about this program.

As a result of this program:	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
a. I am more comfortable talking to my health care provider about my medications and other possible risks for falling.					
b. I am more comfortable talking to my family and friends about falling.					
c. I plan to continue to exercise.					
d. I plan to participate in another fall prevention program.					
e. I was satisfied with the program.					
f. I would recommend this program to a friend or relative.					

Paperwork Reduction Act Public Burden Statement: According to the Paperwork Reduction Act of 1995 5 CFR § 1320.8(b)(3), no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0039). Public reporting burden for this collection of information is estimated to average 0.10 hours per response, including time for gathering, maintaining the data needed, completing, and reviewing the collection of information. The obligation to respond to this collection is required to retain benefits under the statutory authority of the Older Americans Act and Patient Protection and Affordable Care Act. The Administration for Community Living (ACL) will use the set of data collection tools to monitor grantees receiving Evidence-Based Falls Prevention Program cooperative agreements. Data will be kept private to the extent allowed by law. There are no assurances of confidentiality. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Administration for Community Living, U.S. Department of Health and Human Services, 330 C Street, SW, Washington, DC 20201-0008, Attention: Office of Nutrition and Health Promotion Programs (ONHPP), and reference the OMB Control Number 0985-0039. Note: Please do not return the completed Evidence-Based Falls Prevention Program cooperative agreements to this address.