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)

   _____ _____
   First Name Last Name

   Ph: (___) _____ - _____

   Email: _____

   Would you like to receive program information from the National CDSME Resource Center? ☐ Yes ☐ No

   _____ _____
   First Name Last Name

   Ph: (___) _____ - _____

   Email: _____

   Would you like to receive program information from National CDSME Resource Center? ☐ Yes ☐ No

3. Program Start Date (mm/dd/yyyy): __ __/__ __/__ __ __ __
   End Date (mm/dd/yyyy): __ __/__ __/__ __ __ __

4. Did you offer a "Session 0" with this program? (Session 0 is an optional pre-program session. Not all programs offer a Session 0.)

   - O Yes
   - O No
   - O Don't know

5. What type of program is this? Mark only one. [Note to grantee: adapt this section to fit local programming]

   - O Active Living Every Day
   - O Arthritis Foundation Aquatic Program
   - O Arthritis Foundation Exercise Program
   - O BRI Care Consultation
   - O Cancer: Thriving and Surviving
   - O Chronic Disease Self-Management Program (CDSMP)
   - O Chronic Pain Self-Management Program (CPSMP)
   - O Diabetes Self-Management Program (DSMP)
   - O Eat Smart, Move More, Weigh Less
   - O EnhanceFitness
   - O EnhanceWellness
   - O Fit and Strong!
   - O Geri-Fit
   - O Health Coaches for Hypertension Control
   - O Healthy IDEAS
   - O Healthy Moves for Aging Well
   - O HomeMeds
   - O Living Well in the Community
   - O On the Move
   - O PEARLS
   - O Positive Self-Management Program for HIV
   - O Programa de Manejo Personal de la Diabetes (Spanish DSMP)
   - O Screening, Brief Intervention, and Referral to Treatment (SBIRT)
   - O Tomando Control de su Salud (Spanish CDSMP)
   - O Walk With Ease
   - O Wellness Recovery Action Plan (WRAP)
   - O Workplace Chronic Disease Self-Management Program (wCDSMP)

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

- O English
- O Spanish
- O Other: _____

7. What funding source(s) were used to support this program? Check all that apply.

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