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 Email:__________________________
   Ph: (    ) -

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

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

   Would you like to receive program information from the 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.)

   [ ] Yes
   [ ] No
   [ ] Don’t know
5. 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
- EnhanceFitness
- EnhanceWellness
- Fit and Strong!
- Geri-Fit
- Health Coaches for Hypertension Control
- Healthy IDEAS
- Healthy Moves for Aging Well
- HomeMeds
- Living Well in the Community
- On the Move
- PEARLS
- Positive Self-Management Program for HIV
- Programa de Manejo Personal de la Diabetes (Spanish DSMP)
- 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)

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

- English
- Spanish
- Other: ________________________________
7. 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: ________________________________