OMB Control No. 0985-0036
Exp. Date 11/22/2022

TO BE COMPLETED AT LAST PROGRAM SESSION

Admin Use Only:

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.

State abbreviation: __ __ (e.g., NY, VA, MA, etc.)

First four letters of the site name: __ __ __ __

Start date of program: __ __ / __ __ / __ __ (e.g., 12 01 19)

Participant number: __ __ (e.g., 01, 02, 03, etc.)

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Totally sure

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

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never