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

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. 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: _____