

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0036. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 330 C Street SW, Washington, D.C. 20201, Attention: PRA Reports Clearance Officer.