
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

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.

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: _____

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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: _____

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