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

Better Choices, Better Health

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]

   ○ Chronic Disease Self-Management Program (CDSMP)
   ○ Workplace Chronic Disease Self-Management Program (wCDSMP)

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

   ○ English
   ○ Spanish
   ○ Other: ____

7. If you charged the participants a fee to attend this workshop, please indicate the amount: $ _______

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