# Program Information Cover Sheet

*Instructions to the Program Facilitators: 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 New Jersey Dept. of Human Services, Div. of Aging Services.*

1. **Site Name:** 
   - Address: 
   - City: 
   - State: 
   - Zip: 
   - County: 

   *Name of organization licensed to offer program:* 

2. **Program Facilitators’ 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):

<table>
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<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Phone</th>
<th>Staff or Volunteer</th>
<th>Email</th>
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3. **Program Start Date** (*mm/dd/yyyy*): 
   - \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_

   **End Date** (*mm/dd/yyyy*): 
   - \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_

4. **Did you offer a “Session 0” with this workshop?** (Session 0 is an optional pre-workshop session. Not all workshops offer a Session 0.)
   - Yes
   - No
   - Don’t Know

5. **What type of workshop is this?** (Mark only one.)
   - Chronic Disease Self-Management Program (CDSMP)
   - Tomando Control de su Salud (Spanish CDSMP)
   - Diabetes Self-Management Program (DSMP)
   - Manejo Personal de la Diabetes (Spanish DSMP)
   - Cancer Thriving and Surviving Workshop (CTS)
Workshop Information Cover Sheet – continued

6. Please check which language you used when leading this workshop:
   ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Hindi ☐ Vietnamese ☐ Other: ______

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

For Survey Coordinator Use Only:

   Host Organization Name: __________________________________________________________
   Funding Source for this Workshop: ☐ DoAS ☐ OMMH ☐ FHS ☐ Title IID
   ☐ CDC ☐ Other Fed. ☐ Foundation ☐ Fee/Self-Pay ☐ Other: ______

Forms Checklist Examples

Please return the following forms to the Survey Coordinator (contact information below) within one (1) week after the final session:

☐ This Workshop Information Cover Sheet
☐ Attendance Log
☐ All completed Participant Information Surveys

Send completed forms to:
Andrew Biederman
New Jersey Department of Human Services
Division of Aging Services
P.O. Box 807
Trenton, NJ 08625-0807

Questions can be directed to:
Andrew Biederman
Andrew.biederman@dhs.state.nj.us or 609-438-4797