### Program Information Cover Sheet

**Program Facilitator Instructions:** Please print clearly and return this cover sheet with the required data collection forms to the New Jersey Division 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):

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<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” (*an optional pre-workshop session*) with this workshop
   - 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)
   - Programa de Manejo Personal de la Diabetes (Spanish DSMP)
   - Cancer Thriving and Surviving Workshop (CTS)
   - Chronic Pain Self-Management Program (CPSMP)
   - Positive Self-Management Program for HIV
   - Workplace Chronic Disease Self-Management Program (wCPSMP)
   - Building Better Caregivers (BBC)
Workshop Information Cover Sheet – continued

6. Please check which language you used when leading this workshop:
   - English ☐
   - Spanish ☐
   - Other: ______

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

For Survey Coordinator Use Only:

Host Organization Name: _______________________________________________________

Funding Source(s) for this Workshop:

☐ NJDoAS    ☐ NJDOH    ☐ Title III    ☐ ACL Grant

☐ 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