**Workshop Information Cover Sheet**

*Instructions to the Group Leaders: Please provide the requested details about this Workshop. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the New Jersey Department of Human Services.*

1. Site Name: ________________________________  
   Address: ____________________________________________________________  
   City: __________________________ State: __________ Zip: ________________  
   County: ____________________________

2. Name of organization licensed to offer program: ____________________________

3. Workshop Leaders’ Names (please provide full first and last names):  
   If we may contact you with questions about these forms, please provide your daytime phone number as well.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>☐ Staff or</th>
<th>☐ Volunteer</th>
<th>Phone</th>
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4. Workshop Start Date (mm/dd/yyyy): _______ / _______ / _______  
   End Date (mm/dd/yyyy): _______ / _______ / _______

5. 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

6. 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)

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

For Survey Coordinator Use Only

Host Organization Name: ________________________________________________  
Funding Source for this Workshop: ☐ DoAS ☐ OMMH ☐ FHS ☐ Title IIID  
☐ CDC ☐ Other Fed. ☐ Foundation ☐ Fee/Self-Pay ☐ Other: _____
Workshop Information Cover Sheet – continued

8. Number of participants enrolled attending at least 1 session (excluding “Session 0”): ____________

9. Number of participants who completed at least 4 sessions (excluding “Session 0”): ____________

10. Number of Participant Information Surveys included in the returned packet: ____________

   If the number of forms is fewer than the number of participants noted in #9 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.):

   ___________________________________________________________

10. If you charge the participants a fee to attend this workshop, please indicate the amount: _______

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:
Andrea Mancini
New Jersey Department of Human Services
Division of Aging Services
P.O. Box 807
Trenton, NJ 08625-0807

Questions can be directed to:
Keana Reed
keana.reed@dhs.state.nj.us or 609-588-6655