



Take Control of Your Health

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.

<i>First Name</i>	<i>Last Name</i>		<i>Phone</i>
_____	_____	<input type="checkbox"/> Staff or <input type="checkbox"/> Volunteer	_____
_____	_____	<input type="checkbox"/> Staff or <input type="checkbox"/> Volunteer	_____

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:	<input type="checkbox"/> DoAS <input type="checkbox"/> OMMH <input type="checkbox"/> FHS <input type="checkbox"/> Title IIID
<input type="checkbox"/> CDC <input type="checkbox"/> Other Fed. <input type="checkbox"/> Foundation	<input type="checkbox"/> Fee/Self-Pay <input type="checkbox"/> 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