Registration Form

(If not already registered on yourjuniper.org)

First Name*______________ Last Name*______________ Phone______________

Email Address________________________________ Date of Birth*_____________

Address*__________________ City*______________ State*____ Zip*_________

Emergency Contact Name and Phone ______________________________________

Please list any special accommodations ____________________________________

Privacy Policy

To help Juniper track how the program assists people to manage their health issues, and to improve and sustain the program, Juniper may choose to use information you provide to us for these purposes. Information you provide to us may include identifying information and responses to class surveys. Your response to class surveys, other than identifying information, is optional in most cases. By registering for a class, you consent to Juniper's Privacy Policy. Juniper's Privacy Policy, effective December 1, 2017, is to protect and use your information as follows:

- Juniper may aggregate or combine data from class participants and share this combined information with third parties. Your identifying information is removed. Third parties may include healthcare organizations, aging services organizations, private foundations, and federal and state government.
- Juniper may share information with your healthcare provider but only when your provider directly referred you. The information Juniper may share with your healthcare provider is limited to the status of whether you did or did not complete a class.
- Juniper may share information with your health plan but only when your health plan is paying a fee, if any is required, for your participation in a class. The information Juniper may share with your health plan is limited to the status of whether you did or did not complete a class, and further, may share your responses to class surveys. If your health plan is paying a fee for your participation, if any is required, you may be required to complete class surveys.
- Juniper will not sell your personal data to third parties to market or advertise to you.
- Juniper reserves the right to update or modify our Privacy Policy, and when we do so we will update the effective date. Your continued participation in a class constitutes your agreement to our Privacy Policy.

I agree to the terms of the Privacy Policy.

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Participant Signature Date

OMB Control No. 0985-0036
Exp. Date 10/31/2019

Living Well with Chronic Conditions/ Living well with Diabetes

or other programs in Stanford suite

Participant Information Survey

Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): __ __ __ __ __ __

1. How old are you today? ______ years

2. Are you: O Male or O Female?

3. Are you of Hispanic, Latino, or Spanish origin?
   O Yes O No

4. What is your race? Mark all that apply.
   - O American Indian or Alaska Native
   - O Asian
   - O Black or African American
   - O Native Hawaiian or other Pacific Islander
   - O White

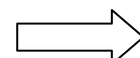
5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

O Arthritis/Rheumatic Disease	O Hypertension (High Blood Pressure)
O Asthma/Emphysema/Other Chronic Breathing or Lung Problem	O Kidney Disease
O Cancer or Cancer Survivor	O Osteoporosis (Low Bone Density)
O Chronic Pain	O Obesity
O Depression or Anxiety Disorders	O Schizophrenia or Other Psychotic Disorder
O Diabetes (High Blood Sugar)	O Stroke
O Heart Disease	O Other Chronic Condition
O High Cholesterol	O None (No Chronic Conditions)

6. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability?

   O Yes O No

Please turn over



7. Are you deaf or do you have serious difficulty hearing?
   O Yes O No

8. Are you blind or do you have serious difficulty seeing even with glasses?
   O Yes O No

9. Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone such as visiting a doctor's office or shopping?
   O Yes O No

10. Do you live alone? O Yes O No

11. What is the highest grade or year of school you completed?
    - O Some elementary, middle, or high school
    - O High school graduate or GED
    - O Some college or technical school
    - O College 4 years or more

12. In general, would you say that your health is:

    O Excellent O Very good O Good O Fair O Poor

13. Did your doctor or other health care provider suggest that you take this program?
    O Yes O No

TO BE COMPLETED AT LAST PROGRAM SESSION

Please circle the number that best matches how confident you are feeling.

14. After taking this workshop, I am more confident that I can manage my chronic condition(s).

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

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.

JUNIPER
Your Health. Your Community.

Living Well with Chronic Conditions/ Living well with Diabetes or other programs in Stanford suite: Participant Pre-Program Supplement Form

Today's date: ____/ ____/________
MM DD YYYY

Please indicate your insurance provider:

○ Aetna ○ Blue Cross Blue Shield of MN ○ HealthPartners ○ Humana ○ Medica
○ PreferredOne ○ UCare ○ Other: ________________________

Are you currently on Medicare? ○ Yes ○ No ○ Unknown

What is the name of your primary physician: ________________________

What is your primary healthcare organization: ______________________

How did you hear about this class?

○ My physician ○ My care coordinator ○ A community organization ○ A family member/friend
○ My insurance company ○ Other: ________________________

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1. As you begin the class, how well do you feel you understand what is involved in the program?
   ○ Extremely well ○ Quite well ○ Moderately well ○ Slightly well ○ Not at all well

2. How confident are you now in your ability to manage your chronic condition?

   Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

3. In general, I would say that my sense of well-being is:
   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

4. Please provide any other information you would like us to know: