



Resources to Prevent and Treat Child/Adolescent Overweight Information Interview Tool

Date:	
Program Name:	
Address:	__ Multiple sites (list on reverse)
Contact Person	
Name _____ Tel. _____ Fax _____ Email _____	
How do interested individuals contact the program?	

Program Type

Focus: Medical Nutrition Physical Activity Behavior

What is the main focus of program?	
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Age/Referral Criteria

Does the program require a referral to enroll? If yes, from whom?	
Does this program serve a specific target population? Or is it open to anyone regardless of age, gender, income, language, culture, etc.?	
Is family participation required?	

Program Description

Describe the main activities and/or goals of the program.	
What is the program format? How is it presented - individual appointment, group, series, self-directed education, classroom, exercise class, etc.?	
What is the length of program, number of classes, days, and dates?	
Is there follow-up and support?	
Does the leader have special credentials?	

Language

What languages are used?	
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Cost

Is there a cost to the program? How much? Covered by Medi-Cal, Healthy Families, private health insurance? What are the payment terms: co-pay, sliding scale, scholarships?	
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Funding Source/Endorsements

Who sponsors this program- health plan, community organization, coalition, commercial, faith based?	
Who endorses the program? Medical organizations, Schools, Public Health Agency?	

Form completed by: _____
Local CHDP Program name/phone #: _____