

Attachment C

**PARTNERS IN CARE
ELIGIBILITY SCREENING**

Today's date: _____	Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth: _____/_____/_____ Month/Day/Year Age: _____
What is your primary ethnicity? <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Filipino <input type="checkbox"/> Chuukese <input type="checkbox"/> White <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Black <input type="checkbox"/> Latino <input type="checkbox"/> Other Pacific Islander _____ <input type="checkbox"/> Other _____	
Has a doctor ever told you that you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemoglobin A1c of 7% or higher? (Assessor: You may need to assess A1c to determine if it is 7% or higher) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you be willing to participate in a diabetes self-management program that would meet 12 times for about 1-hour once a week for 3 months with the possibility of participating in 6 support group meeting for an additional 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure at this time	

Eligible Ineligible