



DIABETES PREVENTION PROGRAM ENROLLMENT FORM

PARTICIPANT REGISTRATION

Last Name:		First Name:		Middle Initial:	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male			Date of Birth:		
Street Address:			Zip Code:		City:
Home Phone:		Mobile Phone:		Does participant give consent to receive automated text alerts to their mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:		Email Address:		Contact Preference: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile <input type="checkbox"/> Mail <input type="checkbox"/> Portal	
Usual Provider (Lifestyle Coach if known; otherwise, select Program Manager):		Registration Department (association location):		Primary Department (class location if known; otherwise leave blank):	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Portuguese <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner		Does candidate's income meet federal poverty guidelines for income status? <input type="checkbox"/> Yes <input type="checkbox"/> No Documentation collected? <input type="checkbox"/> Yes <input type="checkbox"/> No		Education: <input type="checkbox"/> Less than high school <input type="checkbox"/> High school diploma or equivalency (GED) <input type="checkbox"/> Associate degree (junior college) <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate <input type="checkbox"/> Professional (MD, JD, DDS, etc.) <input type="checkbox"/> Other	
Current YMCA Member (also record as a part of Qualification Encounter): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date became member: YMCA Membership (Legacy) ID#: _____		Payer Type: <input type="checkbox"/> MSO Participant <input type="checkbox"/> Direct Payor: _____ <input type="checkbox"/> Self <input type="checkbox"/> Self plus grant/scholarship: _____		Does the candidate give the YMCA consent to call them regarding the YMCA's Diabetes Prevention Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>In athenaNet, make sure to select "paper" for Patient Care Summary.</i>	
Privacy: <input type="checkbox"/> Notice of Privacy Practices (distributed) <input type="checkbox"/> YMCA's Privacy Practices & Assignment of Benefits Form (signed & collected) <input type="checkbox"/> Authorization Form (to send updates to HCP - signed & collected)		Employment: Employer Name: _____ Employer Phone: _____		Consent to Call: Does participant give consent to receive automated calls from athena regarding the program? <input type="checkbox"/> Yes <input type="checkbox"/> No Would the candidate like to register for web portal ? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason: _____	

INSURANCE (MSO PARTICIPANTS) / CASE POLICY (DIRECT PAYOR OR GRANT) INFORMATION (not needed for self-pay participants):

For MSO Participants (if applicable):		
Insurance Company/Plan Name:	Member ID:	Group #:
Claims Address:		
Guarantor (insurance policy holder, if not self) relationship to participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Guarantor Last Name:	Guarantor First Name:
Guarantor Date of Birth:	Guarantor Mailing Address (if different from participant):	Insurance Card Scanned into athenaNet? <input type="checkbox"/> Yes <input type="checkbox"/> No

For Direct Pay or Self Plus Grant/Scholarship Participants (if applicable):

Direct Payor or Grant Case Policy Name:

PARTICIPANT QUALIFICATION

Height:	Weight*:	BMI:
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*Self-Reported. For program participation, BMI ≥ 25 is **required**. Asian individual(s) BMI ≥ 23.

MEETS BLOOD VALUE/DIAGNOSIS QUALIFICATIONS:**
 Check for the criteria below first. If this information is unavailable, proceed to "Meets at-risk Qualifications" section, below.

- A1c: _____ (must be 5.7%-6.4%)
- Fasting Plasma Glucose: _____ (must be 100-125 mg/dL)
- 2-Hour (75 gm glucola) Plasma Glucose: _____ (must be 140-199 mg/dL)
- Prediabetes determined by clinical diagnosis of Gestational Diabetes (GDM) during previous pregnancy

****An individual with a blood value in the normal range cannot be enrolled in the program, even if they meet at-risk qualifications. Blood values are more accurate than risk scores for diabetes risk determination.**

All participants must meet BMI qualification criteria.

MEETS CDC AT-RISK QUALIFICATIONS:		
<i>Complete the questions below based on the candidate's response only if above qualifying information unavailable.</i>		
For each "yes" answer, add the number of points listed.	YES	NO
Is the candidate a woman who has had a baby weighing more than 9 pounds at birth?	1	0
Does the candidate have a parent with diabetes?	1	0
Does the candidate have a brother or sister with diabetes?	1	0
Does the candidate weigh as much as or more than the weight listed for their height? (refer to chart on right)	5	0
Is the candidate younger than 65 years of age and gets little or no activity in a typical day?	5	0
Is the candidate between 45 and 64 years of age?	5	0
Is the candidate 65 years of age or older?	9	0
Total Risk Score (score must be 9 or greater to qualify for enrollment in 'At-Risk' category):		

At Risk Weight Chart	
<i>(BMI should be calculated using a separate resource)</i>	
Height	Weight
4'10	129
4'11	133
5'0	138
5'1	143
5'2	147
5'3	152
5'4	157
5'5	162
5'6	167
5'7	172
5'8	177
5'9	182
5'10	188
5'11	193
6'0	199
6'1	204
6'2	210
6'3	216
6'4	221

PARTICIPANT REFERRAL METHOD:
<input type="checkbox"/> Health care provider <input type="checkbox"/> Media/Marketing <input type="checkbox"/> Screening/testing event or health fair <input type="checkbox"/> Staff member <input type="checkbox"/> Family/friend or word of mouth <input type="checkbox"/> Employer or insurance company <input type="checkbox"/> Past program participant <input type="checkbox"/> Other: _____

PARTICIPANT CLASS PREFERENCES:
Preferred Day of Week:
Preferred Time of Day:
Preferred Class Location: