**REPORT/RENEWAL**

**Due 30 days after your delivery date or by date specified in delivery packet**

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Partner Organization Name: |  | Office Phone #: |  |
| Address: |  | Office Fax #: |  |
| City, State, Zip:  |  | Email address: |  |
| Primary Contact:  |  | Alternate Phone #:*(other than office number)* |  |
| Secondary Contact: |  | Secondary Contact Phone # |  |
| **What services did your program offer incentives for this past distribution? (*Check ONLY those that apply)*** |
|  **🗹 Box**  | **Type of service** | **Education provided to participants** | **# of participants NOT duplicated** |
| [ ]  | Appointments |  |  |
| [ ]  | Home Visits |  |  |
| [ ]  | Classes |  |  |
|  | How many classes were offered?🡪 |  |  |
| What incentive **DID NOT** work for your program or participants and why? |  |
|   |

**Did the Healthy Living Service help your organization meet or make progress towards your goal(s) listed on the request?**

(Circle One) Yes No

**Please let us know how this service helped your organization reach the goal(s). Select your top 2 answers:**

[ ]  Increased Resources [ ]  Increased Community Engagement [ ]  Improved Outreach [ ]  Improved Education

[ ]  Improved Health [ ]  Improved Public Safety [ ]  Improved Programing [ ]  Improved Results

**Please provide an example of how this service helped you to make progress to your goals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| What incentives can we provide that fit the needs of the participants so PWNA can **BETTER** support your program? |  |
|  |

Do you have any referrals, questions or comments about Healthy Living or any other PWNA Services?

|  |
| --- |
|  |

**For another request/delivery for this service please provide the following information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Education for Classes/ Appts/HVs: |  | Number of Participants expected for the next distribution: |  |

|  |  |  |
| --- | --- | --- |
| *Program Partner Primary Contact Signature* |  | *Date* |

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