Community Supports Provider Information Form

Please complete this form and email to CalAIM_providers@healthnet.com to express your interest in becoming a Community Supports (CS) provider. If you intend on servicing more than five counties, please use the online provider interest form.

Request type (check all that applies)

☐New CS provider with our plan ☐Additional CS Services ☐Additional Counties

Provider type: Choose an item. Community-Based Organization (CBO)

If "other", please indicate here:_____

Business information

Company name:_____

Doing business as (DBA) name:_____

Tax ID number:_____ National provider identifier (NPI):_____

If no NPI number exists, have you applied for one and date of doing so?_____

Business address

Street:_____

City:_____ State:_____ Zip Code:_____

Business phone number:_____ Email:_____

Fax number:_____

Mailing address (if different)

Street:_____

City:_____ State:_____ Zip Code:_____

Billing address (if different)

Street:_____

City:_____ State:_____ Zip Code:_____

Contract signatory name:_____Title:_____

Phone number:_____ Email:_____

Daily operations contact name:_____Title:_____

Phone number:_____ Email:_____

23-1505/FRM912807EH01w (12/23)

County Key

Amador	Imperial	Los Angeles	Sacramento	Tulare
Calaveras	Inyo	Madera	San Joaquin	Tuolumne
Fresno	Kings	Mono	Stanislaus	

Community Supports Service (check all that applies)	**County:** Where the Community Supports service is offered (refer to the County Key above and list as applicable). **Capacity:** The number of members your organization can serve at time of implementation. **# of FTE:** The number of employed full-time employees (FTEs).				
☐ Housing Transition Navigation	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Housing Deposits	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Housing Tenancy and Sustaining Services	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Short-term Post Hospitalization	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____

☐ Recuperative Care (Medical Respite)	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Day Habilitation Programs	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Nursing Facility Transition to Assisted Living such as RCFE and ARF	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Community Transition Services/Nursing Facility Transition Services to a Home	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Personal Care and Homemaker Services	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Environmental Accessibility Adaptations or Home Modifications	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____

☐ Medically Supportive Meals and Medically Tailored Meals	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Sobering Centers	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Asthma Remediation	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____
☐ Respite Services	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTE:_____

Please identify capacity limitations or other information you would like to share regarding your ability to provide service(s).

Please list all NPIs, addresses and counties that you will be servicing for CS

NPI	Address	County