Medi-Cal Member Recommendation for Community Health Worker Services

I declare that the following information is true and correct:

1. I am a Physician, Clinical Nurse Specialist (CNS), Dentist, Licensed Clinical Social Worker (LCSW), Licensed Educational Psychologist (LEP), Licensed Marriage & Family Therapist (LMFT), Licensed Midwife, Licensed Professional Clinical Counselor (LPCC), Licensed Vocational Nurse (LVN), Nurse Midwife, Nurse Practitioner (NP), Pharmacist, Physician Assistant (PA), Podiatrist, Registered Nurse (RN), Psychologist, Public Health Nurse (PHN), or Registered Dental Hygienist (RDH).
2. I attest that the Medi-Cal Member listed below would benefit from Community Health Worker services.

Member last name: _____

Member ID#/CIN#: _____

Provider type: _____

Provider name: (print) _____

Provider signature: _____ **Date:** _____

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