

## Community Health Worker Provider Information Form

Please complete this form and email to [CalAIM\\_providers@healthnet.com](mailto:CalAIM_providers@healthnet.com) to express your interest in becoming a Community Health Worker (CHW) provider. If you intend on servicing more than five counties, please use the online *Provider Interest Form*, available on [provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com) > CalAIM Resources for Providers > *Data Collection* > *Provider Interest Form* or at <https://bit.ly/CalAIMResourcesforProviders>.

### Request type (check all that applies)

- ☐ New CHW provider ☐ Additional counties.

Select provider type (check one)			
<input type="checkbox"/> Community-Based Organization	<input type="checkbox"/> Hospital	<input type="checkbox"/> Individual Licensed Provider	<input type="checkbox"/> Outpatient Clinic
<input type="checkbox"/> Local Health Jurisdiction	<input type="checkbox"/> Other (please indicate):		

### 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? \_\_\_\_\_

Website: \_\_\_\_\_

### Business address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Business phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Fax number: \_\_\_\_\_

### Billing/mailling address (if different)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Contract signatory name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Daily operations contact name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

## Requirements:

### 1. Medi-Cal certification is required for all providers working with managed care plans.

Is your organization Medi-Cal certified? ☐ Yes ☐ No

If yes, provide Medi-Cal Number:

\_\_\_\_\_  
If no, then you can validate or enroll through the Department of Health Care Services Provider Application and Validation for Enrollment (PAVE) at [www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx).

### 2. Are you an Enhanced Care Management (ECM) and/or Community Supports (CS) provider?

☐ ECM ☐ CS

#### CHW Employees by Service Area (Counties)

Provide the number of **active CHWs** in each county your organization plans to contract for. If your organization provides services in Emergency Departments (ED), the number of CHWs can be duplicative.

County	# of active CHWs	# of CHWs in ED settings	Engagement (in-person vs virtual)
Amador			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Calaveras			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Fresno			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Imperial			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Inyo			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Kings			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Los Angeles			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Madera			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Mono			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Sacramento			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
San Joaquin			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Stanislaus			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Tulare			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual
Tuolumne			<input type="checkbox"/> In-person <input type="checkbox"/> Virtual

### 1. What type of services from the list below do your CHW promotores/representatives workforce provide?

Select all that apply.

- ☐ Advocacy.
- ☐ Asthma prevention services (certification required).
- ☐ Capacity-building.
- ☐ Care coordination, case management, or system navigation.
- ☐ Cultural mediation among individuals, communities and systems.
- ☐ Direct service.
- ☐ Domestic violence prevention (certification required).

- ☐ Evaluation and research.
- ☐ Health education and information.
- ☐ Individual and community assessments.
- ☐ Outreach.
- ☐ Refer to transitional care services, enhanced care management, community supports, doula or other plan services.
- ☐ Social support.
- ☐ Other (Please specify): \_\_\_\_\_

**2. Please select the type of population(s) whom your CHW promotores workforce serves. (Select all that apply)**

- ☐ Adult nursing facility residents transitioning to the community.
- ☐ Adults at risk for long term care institutionalization.
- ☐ Adults without dependent children/youth experiencing homelessness.
- ☐ Children and youth involved in child welfare.
- ☐ Children enrolled in California Children's Services (CCS) or CCS Whole Child Model.
- ☐ Immigrants.
- ☐ Individuals at risk for emergency department utilization.
- ☐ Individuals or families experiencing homelessness.
- ☐ Individuals transitioning from incarceration.
- ☐ Individuals with serious mental health and/or substance use disorders.
- ☐ Lesbian, Gay, Bisexual, Transgender, Intersex, Ally/Asexual + community.
- ☐ Migrant and seasonal farmworkers and their families.
- ☐ Military veterans.
- ☐ Older adults.
- ☐ People with disabilities.
- ☐ People with intellectual or developmental disabilities.
- ☐ Pregnant and post-partum individuals.
- ☐ School children.
- ☐ Other (Please specify): \_\_\_\_\_

3. Please select all of the areas of support your CHW promotores/representatives workforce can assist with:

- ☐ Promotion of primary care engagement of unengaged members.
- ☐ Support chronic disease management services.
- ☐ Support general care management services (non- Community Care Management (CCM), non-ECM).
- ☐ Support outreach for CCM or ECM enrollment.
- ☐ Support peripartum care.
- ☐ Support services which address social drivers of health.
- ☐ Support utilization of behavioral health navigation services.
- ☐ Support utilization of transitional care services.
- ☐ Utilization of adult preventive care service.
- ☐ Utilization of pediatric preventive care services.
- ☐ Other services: If yes, list additional services in the comments section below.

**Comments:**