Community Supports Provider Information Form (PIF)

Please complete this form and email to CalAIM@Centene.com to express your interest in becoming a new Community Supports (CS) provider or interest in expanding your contract with Health Net*, on behalf of Community Health Plan of Imperial Valley. When submitting back to the Plan, include in the subject line "**Community Supports PIF: [Your organization's name].**"

The Plan is seeking to contract with organizations that have experience and expertise providing Community Supports services to Medi-Cal beneficiaries. All contracted entities are required to follow applicable state and county guidelines in addition to the Plan's requirements. If you have any questions or concerns as you are completing the tool, contact the Plan at the email above.

Please note that submitting the PIF does not guarantee that the Plan will contract with your organization. PIFs will be reviewed twice a year and selected providers will be invited to apply. If your organization is not invited to move forward in the process, the Plan will let you know via email.

Request type (check all that apply)

☐ New CS provider with our plan. ☐ Additional CS services. ☐ Additional counties.

Provider type: Choose an item.

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?_____

Website: _____

Business address

Street:_____

City:_____ State:_____ ZIP Code:_____

Business phone number:_____ Email:_____

Fax number:_____

Billing/Mailing 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. **Electronic Visit Verification (EVV) is required for Personal Care and Homemaker Services, Day Habilitation and Respite Services. This is a requirement at the direction of the Department of Health Care Services (DHCS).**

   Are you applying to provide any of the services listed above? ☐ Yes ☐ No

   If yes, have you registered for EVV? ☐ Yes ☐ No

   If no, register through DHCS at www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx. This can be completed at the same time with your PIF form submission.

2. **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 DHCS Provider Application and Validation for Enrollment (PAVE) at www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx. We recommend submitting the PAVE enrollment request first, then submit the PIF form after. We can review your documentation while DHCS processes your PAVE application.

3. **Are you a contracted provider for the following services? (select all that apply)**

   ☐ Enhanced Care Management (ECM) ☐ Community Health Worker (CHW) ☐ Doula ☐ N/A

Please complete the questions below for the Community Supports service(s) your organization is interested in offering. Feel free to attach additional documentation explaining your experience in providing these services.

1. **Organization Overview:** Provide details of your organization's current services/programs that are related to the Community Supports you are interested in providing.

2. **Organization Staffing:** Share the staffing model(s) of your service delivery team(s) for the Community Supports you are interested in providing.

3. **Organization's Organic Referrals:** Describe your existing organic referral partnerships and the types of organizations involved. Do you use any community resource platforms (i.e., Findhelp, 211, One Degree) to make or receive referrals?

County Key

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

Community Supports (CS) Service (check all that applies)	**County:** Where the CS service is offered (refer to the County Key above and list as applicable). **Initial Capacity:** The number of members your organization can serve at time of implementation. **Capacity after 12 Months**: Forecast the number of members your organization can serve 12 months after implementation. This does not have to be accurate, just an estimate will suffice. **# of FTE:** The number of employed full-time employees (FTEs).				
Services to address homelessness and housing					
☐ 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:_____
☐ 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:_____
☐ Transitional Rent	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:_____

Services for long-term well-being in home-like settings					
☐ 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:_____
☐ 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:_____
☐ 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:_____
☐ 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:_____

Services for long-term well-being in home-like settings, *continued*					
☐ Nursing Facility Transition to Assisted Living such as Residential Care Facilities for Elderly and Adult Residential Facilities	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:_____
Recuperative services					
☐ 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:_____
☐ 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:_____
☐ 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 services, *continued*					
☐ 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:_____

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