Enhanced Care Management Provider Information Form

Please complete this form and email to CalAIM_providers@healthnet.com to express your interest in becoming an Enhanced Care Management (ECM) provider. If you intend on servicing more than five counties, please use the online provider interest form available on 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 ECM provider with our plan. ☐ Additional population of focus. ☐ Additional counties.

Provider type: Please select Provider Type

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:_____

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:_____

25-171 (4/25)

Requirements:

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.

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County Key

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

Population of Focus (check all that applies)	**County:** Where the ECM 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 would suffice. **# of FTE:** The number of employed full-time employees (FTEs).				
☐ Adults Experiencing Homelessness	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:____ # of FTEs:_____
☐ Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:____ # of FTEs:_____
☐ Adults With Serious Mental Illness and/or Substance Use Disorder (SUD) Needs	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____

☐ Adults Transitioning From Incarceration	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Adults Living in the Community Who Are at Risk for Long-Term Care (LTC)	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Nursing Facility Residents Transitioning to the Community	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Birth Equity (Adults Pregnant or Postpartum (Through 12 Month Period) Individuals and Are at Risk for Adverse Perinatal Outcomes)	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
For the below sub-population of focus, FTE and capacity indicated in the above will also apply to this.					
☐ Adults Who Have a Diagnosed Intellectual/Developmental Disability (I/DD)	County:_____	County:_____	County:_____	County:_____	County:_____

☐ Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Children/Youth at Risk for Avoidable Hospital or ED Utilization	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Children/Youth With Serious Mental Health and/or SUD Needs	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Children/Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs Beyond the CCS Condition	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Children/Youth Involved in Child Welfare	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____

☐ Children/Youth Who Are Transitioning From a Youth Correctional Facility Setting	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
☐ Birth Equity (Youth Pregnant or Postpartum (Through 12 Month Period) Individuals and Are at Risk for Adverse Perinatal Outcomes)	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____	County:_____ Capacity: Initial:_____ After 12 months:_____ # of FTEs:_____
For the below sub-population of focus, FTE and capacity indicated in the above will also apply to this.					
☐ Children/Youth With Intellectual or Developmental Disabilities (I/DD)	County:_____	County:_____	County:_____	County:_____	County:_____

☐ Please check this box if you only want to be assigned members who are part of your primary care panel.

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 ECM.

NPI	Address	County