



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

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: _____



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.

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.



County Key

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

<p>Community Supports (CS) Service (check all that applies)</p>	<p>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 would suffice. # of FTE: The number of employed full-time employees (FTEs).</p>					
	<input type="checkbox"/> 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: _____
	<input type="checkbox"/> 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: _____
	<input type="checkbox"/> 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: _____
	<input type="checkbox"/> 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: _____



<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____

<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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).

