Enhanced Care Management Provider Information Form (PIF)

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

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

Please note that submitting the PIF does not guarantee that Health Net 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, Health Net will let you know via email.

Request type (check all that apply)

☐ New ECM provider with our plan. ☐ Additional populations of focus. ☐ 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:_____

25-686 (7/25)

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.

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

   ☐ Community Supports (CS) ☐ Community Health Worker (CHW) ☐ Doula ☐ N/A

Please complete the questions below for the population of focus 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 population of focus you are interested in providing.

2. **Organization Staffing:** Share the staffing model(s) of your service delivery team(s) for the population of focus 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	

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).				
ECM services offered to adults					
☐ Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization	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:_____
☐ Adults Experiencing Homelessness	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:_____
☐ Adults Living in the Community Who Are at Risk for Long-Term Care (LTC)	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:_____
☐ Adults Transitioning From Incarceration	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:_____

ECM services offered to adults, *continued*					
☐ Adults With Serious Mental Illness and/or Substance Use Disorder (SUD) Needs	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:_____
☐ 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 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:_____
☐ Nursing Facility Residents Transitioning to the Community	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:_____
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:_____ 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:_____

ECM services offered to children/youth					
☐ 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 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:_____
☐ Children/Youth at Risk for Avoidable Hospital or ED Utilization	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:_____
☐ 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 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:_____
☐ Children/Youth Involved in Child Welfare	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:_____
☐ Children/Youth Who Are Transitioning From a Youth Correctional Facility Setting	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:_____

ECM services offered to children/youth, *continued*					
☐ Children/Youth With Serious Mental Health and/or SUD Needs	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:_____
☐ Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	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:_____
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:_____ 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 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