Community Supports Reference Guide

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1 Introduction

Community Supports (CS) are key services offered by California Advancing and Innovating Medi-Cal (CalAIM), a Department of Health Care Services (DHCS) initiative to address the social determinants of health and improve health equity statewide. CS services are medically appropriate and cost-effective alternatives to state plan services. DHCS has pre-approved 14 CS services to address the needs of members – including those with the most complex challenges affecting health, such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs.[1]

CalViva Health (the Plan) has launched all 14 DHCS pre-approved CS services over a span of two years. The following CS services are available to members.

Services to Address Homelessness and Housing

Community Supports	Description
Housing Deposits	**Funding for one-time services necessary to establish a household**, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.
Housing Transition Navigation	**Assistance with obtaining housing**. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.
Housing Tenancy and Sustaining Services	Assistance with **maintaining stable tenancy once housing is secured**. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services to develop financial literacy.

Recuperative Services

Community Supports	Description
Recuperative Care (medical respite)	**Short-term residential care for beneficiaries who no longer require hospitalization, but still need to recover** from injury or illness.
Respite Services	**Short-term relief provided to caregivers** of beneficiaries who require intermittent temporary supervision.
Short-Term Post Hospitalization Housing	**Setting in which beneficiaries can continue receiving care** for medical, psychiatric, or substance use disorder needs immediately **after exiting a hospital**.
Sobering Centers	**Alternative destinations for beneficiaries who are found to be intoxicated** and would otherwise be transported to an emergency department or jail.

Services for Long-Term Well-Being in Home-Like Settings

Community Supports	Description
Asthma Remediation	**Physical modifications to a beneficiary's home to mitigate environmental asthma triggers.**
Day Habilitation Programs	**Programs provided to assist beneficiaries with developing skills necessary to reside in home-like settings**, often provided by peer

[1] As of DHCS Community Supports Policy Guide July 2023, and subject to further change by DHCS.

Community Supports	Description
	mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.
Environmental Accessibility Adaptation (Home Modification)	**Physical adaptations to a home to ensure the health and safety of the beneficiary**. These may include ramps and grab bars.
Medically Tailored Meals	**Meals delivered to the home that are tailored to meet beneficiaries, unique dietary needs**, including following discharge from a hospital.
Nursing Facility Transition/Diversion to Assisted Living Facilities	**Services provided to assist beneficiaries transitioning from nursing facility care to community settings** or prevent beneficiaries from being admitted to nursing facilities.
Community Transition/Nursing Facility Transition to Home	**Services provided to assist beneficiaries transitioning from nursing facility care to home settings** in which they are responsible for living expenses.
Personal Care and Homemaker Services	**Services provided to assist beneficiaries with daily living activities**, such as bathing, dressing, housecleaning, and grocery shopping.

The key goal of the pre-approved CS services is to allow members to receive care in settings where they feel most comfortable and to keep them in their home or the community, as medically appropriate. A list of eligibility criteria for each CS service can be found in section 6 of this guide.

To check for CS services by county, refer to the provider directory. However, please note that specific CS services by county may be subject to change depending on network availability and other factors.

2 Provider Certification Application

The purpose of the CS provider certification process is to certify organizations that are qualified to serve as a CS provider. The Plan uses the certification process to evaluate and verify the potential CS provider's ability to comply with the CS service requirements as outlined by DHCS and the ability to submit data files and claims.

To become a CS provider, organizations should review the requirements and criteria described in the DHCS Community Supports Policy Guide. Providers must submit a Provider Interest Form (PIF) to the appropriate health plan contacts and identify the counties and CS services for which they would like to contract. The health plan will invite select organizations to submit the CS Provider Certification Application with accompanying documentation to support their application and work with the health plan to establish an understanding of the CS requirements, such as services offered, populations served, staffing and capacity, and readiness to provide the services indicated. Together, the prospective CS provider and the health plan will determine where additional effort(s) will be necessary to meet the contracted CS provider requirements.

The health plan and CS provider will discuss and agree on a readiness and gap closure plan to ensure the CS provider's readiness by the agreed upon go-live date and expectations following the go-live date into program administration. The key areas of focus for the readiness and gap closure plan are driven by the required areas and CS services selected in the CS Certification Application:

Required Areas of Focus
General Provider Section 1A-1J • 1A: General Provider Information • 1B: Experience Servicing Medi-Cal Beneficiaries

Required Areas of Focus
• 1C: Provision of Community Supports Services • 1D: Outreach and Engagement • 1E: Enrollment and Member Consent • 1F: Care Coordination • 1G: Referral to Community and Support Services • 1H: Cultural and Linguistically Appropriate and Non-Discrimination Service Requirement • 1I: Claims and Invoice Submission • 1J: Data Sharing to Support Community Supports
Community Supports – specific section applies to selected CS service • Section A: Community Supports Description • Section B: Provider Capabilities and Best Practices • Section C: Eligibility Criteria • Section D: Provider Staffing and Capacity

The health plan cannot certify a CS provider who is unable to fulfill the CS requirements and/or is determined to not be able to meet CS requirements. Therefore, the prospective CS provider will not be contracted to provide CS services under the CS benefit.

3 Contracting

CS providers moving forward into contracting will receive an email from the health plan's contracting department to establish and execute a contract. CS providers will work directly with their health plan contact to plan for and prepare to provide CS services by the agreed upon start date.

For providers who are interested in contracting for CS or Enhanced Care Management (ECM), providers also have the option to complete the Network Participation Request Form on the provider website. Upon receipt of the form, the request will be routed to the appropriate health plan contacts to begin the certification application review process.

4 Training Requirement

The Plan provides onboard training and technical assistance to all contracted CS providers. Trainings are in an on-demand and live format. CS providers will receive communications about all required onboard trainings. At least one person in the organization is required to complete the onboard training. An attestation will be required to confirm completion of the trainings prior to contracting. Additionally, CS providers are expected to participate in all mandatory, provider-focused CS training and technical assistance provided by the health plan, including in-person sessions, webinars, and/or calls, as necessary. A current list of trainings can be found on the CalAIM Resources for Providers website – Training & Webinars section.

5 Community Supports Authorization Guides

CS authorization guides provide guidance to CS providers based on DHCS eligibility criteria and differ for each CS service. The authorization guides include information such as:

Program Overview	Services the members will receive with this community support.
Eligibility	Eligibility criteria for the community support.

Authorization	Length of time the CS service is offered for the initial authorization and reauthorization (as applicable).
Required Documentation	Documentation that must be submitted to the health plan for authorization approval.
Codes	Healthcare Common Procedure Coding System (HCPCS) codes that must be used for documenting the rendering of ECM & Community Supports services.

An authorization request is not required for sobering center services. Use the authorization guide for service information and eligibility criteria. Authorization guides can be accessed on the CalAIM Resources for Provider website under *Forms and Tools*.
Providers can access the CS Authorization Guides, which follow the guidance from DHCS Community Supports Policy Guide.

6 Referral Process

There is a "no wrong door" approach with the referral process. The health plan accepts referrals from ECM providers, other providers, other entities serving members, family member(s), guardian, caregiver, and/or other authorized support person(s) and is not limited to members engaged with an ECM provider. There are several ways a referral can be made to CS providers. Below are processes for identifying and referring members to CS services electronically, through findhelp or manually, through fax.

6.1 Electronic – findhelp

The Plan partnered with findhelp, formerly known as Aunt Bertha, to identify local resources, support staff and community partners when searching for local services. Findhelp is a social service platform that makes it simple to find and connect to free and reduced cost community programs to address social needs. The platform has thousands of programs across the nation, spanning all domains of need – from food pantries to financial assistance to housing support, and more.

Findhelp is the access point where all contracted CS providers connect with members, check member eligibility and promote program services. The platform increases the visibility of CS programs, creates an efficiency for staff and ECM providers to search for CS services, making it easy to use when referring members to CS providers and closing the loop on referrals.

CS providers have the ability to claim their program on the findhelp platform. Claiming ownership allows providers to access their program card, and the ability to directly manage and update their program information on findhelp. Use the CalAIM findhelp platform to make a referral, connect with the member to provide services, update the status, and close the loop on referrals in coordination with ECM providers. Additionally, CS providers can refer a member to another CS provider using the platform.

Go to the CalAIM findhelp webpage to manage the member's profile and referral statuses. Reference the Findhelp How To Guide, which is a step-by-step tool to help CS providers navigate the findhelp platform.

6.2 Manual – Fax

1. Utilize the CS authorization guides to determine eligibility. Find CS authorization guides on the CalAIM Resources for Providers.
2. Identify CS providers through the Provider Directory.
3. Contact the CS provider and provide them with the member's contact information and supplemental information used to determine eligibility.

Members can self-refer directly to a CS provider. The CS provider will assess the member for the CS service, determine eligibility and obtain consent to provide services.

What Happens After Referral to CS Provider?

Providers will need to call the CS provider directly to check on the referral status.

6.3 CS Providers Referring to ECM

CS providers can refer a member to ECM providers if the member is eligible for ECM based on the DHCS guidelines. Providers can make a referral by using the options below:

- Fax the member's information that supports their ECM eligibility to the Plan at 800-743-1655.
- Submit an ECM referral request through the provider portal. ECM referral and screening forms can be found at CalAIM Resources for Providers > *Forms and Tools* > *Enhanced Care Management (ECM)*. CS providers are not required to use the forms, they are provided as optional tools.

However, if the referring provider submits a referral for a member that is already assigned to another ECM provider, a non-eligible status will be issued as unable to process and a letter will be sent to the referring provider.

7 Outreach and Member Engagement

Outreach and member engagement to members is critical to the success of the program. CS providers are responsible for reaching out to each assigned and referred members to their organization for services. CS providers must engage with each member to determine eligibility and enroll into CS service.

CS providers are expected to conduct outreach primarily through in-person interaction where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community, subject to public health protocols. CS provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with member's consent. The CS provider must use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences: email, texts, phone calls and telehealth. The Plan requires CS providers to initiate outreach and complete at least five outreach attempts within 30 calendar days of the receipt of the referral. At least three different modalities will be used in attempt to reach the member before a member is identified as an unsuccessful engagement.

Once the CS provider determines that a member is not reachable within 30 days, the member declines to participate, continues to disengage or meets an exclusion criterion, the CS provider is expected to exclude the member from further outreach and report the information to the referring entity and CS return transmission file.

8 Member Authorization Request

8.1 Confirm Member Eligibility

CS providers are required to verify member's health plan eligibility. The member's eligibility must be confirmed during initial contact to make sure the member qualifies for CS services and/or is enrolled in any duplicative care coordination programs. For additional information on qualification criteria for any of the covered CS services, CS providers can access the CS Authorization Guides. Thereafter, CS providers can submit an authorization request for CS services requiring prior authorization through the provider portal or fax the request to the health plan, and determinations can be viewed in the provider portal in real time. If

the member meets the CS eligibility criteria, the provider will be authorized to conduct CS services for the member. A letter informing the member and referring/servicing provider will be sent as confirmation.

If there is not enough information included with the referral to confirm CS program eligibility, the health plan will request additional information. Based on information received, the health plan will render a decision to authorize or deny services.

8.2 Provider Portal for Authorization

The Plan has a variety of methods to submit an authorization request. However, it is recommended to submit through the provider portal. The provider portal is a secure web-based platform that can be used to verify a member for their current eligibility status and access to real-time status updates.

CS providers can create new authorizations and follow the step-by-step guidance to complete an authorization request for the CS service(s).

1. Log in to the provider portal.
2. Verify member is eligible with the Plan and qualifies for CS (use CS authorization guides as a tool to determine member qualifications: CS Authorization Guides.
3. Click on the Auth tab and select create a new auth.
4. Under service type select the option for Community Supports.
5. Enter your NPI as requesting and servicing provider.
6. Enter the diagnosis codes that help determine member's eligibility.
7. Attach any documents (i.e. assessment, diagnosis) that support the authorization request.
8. Enter all other requested information including service, procedure code, etc., and click submit.

For recuperative care, we highly encourage hospitals to submit the authorization request for their patients with the discharge plan to avoid in delay in recuperative services for members. The Plan will review the referral information to make a determination on eligibility for the CS service.

8.2.1 Supporting Documentation

Supporting documentation must be submitted with the authorization request in order to confirm member eligibility. Supporting documents can be attached to the authorization request in the Provider Portal and minimize delays in determining the authorization request. Use the CS referral forms as a reference when submitting supporting documents.

8.2.2 Authorization Review Process

The Plan will enter the request into the Plan's clinical documentation system to track and monitor all authorizations and validate the member's benefit and eligibility. The Plan will process requests and make a determination based on medical appropriate criteria.

Determinations can be viewed in the provider portal in real-time. A letter informing the member and referring/servicing provider will be sent as confirmation. The timing of decisions will be consistent with the urgency of the member situation. Examples of urgent services would be recuperative care, housing navigation and housing deposits. Expedited requests will be processed within 72 hours and routine requests will be processed within five business days. Turnaround time is dependent on the receipt of all clinical information necessary to render a decision.

8.3 Other Alternatives

8.3.1 Email

At this time, the Plan is not accepting authorization requests via email.

8.3.2 Fax

CS providers may submit authorization requests by fax at 800-743-1655. The Plan does not have a specific CS authorization form. However, providers have the option to use the generic authorization form that the Plan provides as a cover page on top of the supporting document the provider is sending in. The authorization form can be found at the Plan's Prior Authorization webpage.

Additionally, to provide more flexibility, CS providers may use their own organization's form or an authorization form that they are currently using from the Plan. Authorization request forms must contain the member information, their primary diagnosis, and supporting documents to show why the member qualifies for the requested CS service(s).

9 Claims and Invoice Submission

9.1 Claims vs Invoice Submission

CS providers are required to submit a claim or an invoice for CS services to the Plan using the codes set by DHCS as evidence to all CS services provided to members. CS providers must follow the guidance of their contract and authorization letter. Claims or invoice should be submitted within 180 days of date of service to meet timely filing requirements.

9.1.1 Claims

There are two ways to submit claims to the Plan; electronically (preferred method) and manually (paper claims).

1. Electronic claims submission will require the use of a clearinghouse; the clearinghouses that the Plan accepts claims directly from are Availity and Ability.

When submitting electronic claims, use the following payor ID number to ensure the claims are routed correctly:

Line of Business	Health Net Payer ID
Medi-Cal	95567

Clearinghouse	Contact Information	Health Net Payer ID
Ability (MDOnline)	888-499-5465 www.mdon-line.com	95567
Availity	800-282-4548 www.Availity.com	68069

Once the provider has enrolled with one of the above clearinghouses the provider will be able to complete 837 electronic claim submission, 835 electronic remittance advice (ERA), and EFT payments.

- The 837 electronic claim form is the electronic form that is used when submitting claims for reimbursement.

- 835 electronic remittance advice (ERA) files give providers details regarding multiple claims, allowing the adjudicated claim information to automatically post to accounts receivable systems.
- EFT payments are the electronic mechanism used to instruct Depository Financial Institutions (DFIs) to move money from one account to another.

2. Paper claims submission will require CS providers to submit fee-for-service professional claims on the paper CMS-1500 (02/12) claim form, EDI 837 professional, or the Plan's invoice form. The forms can be mailed to the addresses below.

Line of Business	Address
Medi-Cal	Health Net Cal Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020

9.1.2 Invoices

All paper **CalViva Health Invoice forms** and supporting information must be submitted to one of the options below.

Email:	CalAIM_CS_invoicesubmission@centene.com
Address:	Health Net – Cal AIM Invoice PO Box 10439 Van Nuys, CA 91410-0439
Fax:	833-386-1043
Conduent Web Portal	https://calaim.portal.conduent.com/

For detailed information and official forms for manual submission and/or to enroll in electronic claims submission, visit the CalAIM Resource page.

9.2 Claims Code

CS providers are required to comply with standard coding practices and must submit claims accordingly for the CS services provided. The Plan uses Healthcare Common Procedure Coding (HCPC) and modifier codes as defined by DHCS as evidence for all CS services provided to members. All codes can be found on the Plan's Claims Procedures.

9.3 Conduent

Conduent is a web portal CS providers can use to submit **invoices only**. Follow the below steps to set up an account for Conduent.

1. Send email request for a username and password to: CalAIM_CS_invoicesubmission@centene.com.
2. Include the following information:
    a. "Conduent Provider Portal Access Request" in the subject line of the email.
    b. "Requesting user and password for the CalAim provider portal" in the body of the email.

c. Also include email, first and last name, and phone number.

3. Detailed information on using Conduent can be found on the Plan's Claims Procedure.

9.4 Payment to Providers

The Plan will pay contracted CS providers for the authorized CS services in accordance with the contract established between the Plan and CS provider. The Plan will pay all claims or invoices within 45 business days. The date of receipt will be the date the Plan receives the claim, as indicated by its date stamp on the claim. The payment date will be the date on the check or other form of payment.

10 Programs and Services for Members

10.1 Population Health Management

The Plan supports the member's physical, emotional, and behavioral health through disease and chronic condition management programs to provide education, care coordination, and support to our members with certain chronic conditions. The Plan refers to this program as Population Health Management (PHM). CS providers can get information about diabetes management, pregnancy and postpartum care, asthma treatments and more. It is part of the Plan's commitment to help all the populations we serve healthy across every stage of life.

Visit the Population Health Management's web page for additional information or programs available to members at no cost.

10.2 Health Education

The health plan offers members access to many wellness programs and services to live a healthy lifestyle. Best of all, the programs are offered at no cost. To learn more about the programs and services listed below, contact the Plan's Health Education Information Line at 800-804-6074 (TTY:711) or visit the Health Education website.

Health Education Programs	Description
Fit Families for Life	Help members learn how to eat the right foods and how to stay active to achieve a healthy weight.
Diabetes Prevention Program	Assist members with support and tools to lose weight and reduce their risk of getting type 2 diabetes and heart disease.
Healthy Hearts, Healthy Lives	Members have access to a heart health prevention toolkit and disease management (educational booklets) to learn how to maintain a healthy heart.
Kick It California Stop Smoking Program	Provide advice and information on proven techniques to quit smoking from Kick It California.
Pregnancy Program	Teach pregnant members how to have a healthy pregnancy. Gain support from a case manager if needed.
Health Library	Contains various topics to help members and their family stay healthy.
myStrength®	Offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic conditions, pain management, insomnia and many other conditions.

10.3 Transportation Services

The health plan covers member transportation for health care and services. This is also known as routine medical transportation. There is no added cost for this service. Use the benefit when members need a ride to:

- Their doctor.
- Their dentist.
- Their counselor.
- The pharmacy, to pick up medicine.
- Pick up durable medical equipment, such as a wheelchair or walker.
- Ongoing care, such as dialysis.
- Their home from the hospital.

How the benefit works? The types of rides CS providers can schedule for members.

- Non-emergency medical transportation (NEMT):
  - Vehicles with wheelchairs and gurneys
  - Call 48 hours in advance
- Non-medical transportation (NMT):
  - Car, van, taxi, rideshare and mass transit
  - Call 24 hours in advance
  - Rideshare arrives within one hour

CS providers can schedule rides for members to any place that offers medical care or health care services. There is no mileage limit.

Please note: Mass transit rides must be scheduled five days in advance to allow time for bus passes and/or tokens to be mailed to member.

For member to reserve a ride:

- Call Modivcare at 855-253-6863. Hearing-impaired members, call TTY: 711.
- Call between 7 a.m. and 7 p.m. Pacific time, Monday through Friday.
- When making your reservation, let the Modivcare representative know if you need interpreter services during the transport or call the number on the back of their member ID card for assistance.
- Members should not call more than 30 days before their health care visit to reserve a ride.
- If member is not able to call, a family member, caregiver or doctor can call for them.

Member should have the following information ready when they reserve a ride:

The health plan's member ID number.

- Name and address of medical doctor.
- Appointment date and time.
- Pick-up time and address.

If member has a complaint or needs help to resolve an issue, please have them contact the Plan's Member Services Department toll free at 888-893-1569 (TTY: 711), 24 hours a day, 7 days a week.

10.4 Telehealth

The health plan works with Teladoc Health (Teladoc®) to deliver telehealth care to members at no additional cost. Teladoc is a mobile telehealth/telemedicine app that combines the power of artificial intelligence (AI) with human medical expertise. Members can meet with a licensed physician via phone and/or video.

This service is for non-emergency medical and behavioral health issues. With the Teladoc app, members will receive access to in-network health care providers. Medical appointments are available 24/7. Behavioral health appointments are available 7 a.m. to 7 p.m. (Pacific time).

11 Monitoring and Support

11.1 Monitoring and Support Overview

The health plan will monitor CS provider performance and compliance with CS requirement using a variety of methods which may include utilization metrics, monitoring calls, on-site visits, timely submissions of reports, audits and/or corrective actions, as needed. CS provider acknowledges that the health plan will conduct oversight of its participation in CS to ensure the quality of services and ongoing compliance with program requirements using the modalities listed. The CS provider must respond to all the health plan's requests for information and documentation to permit ongoing monitoring of CS.

Documentation System

CS providers must use a documentation system or process that supports the integration of physical, behavioral, social service, and administrative data and information from other entities. This includes the health plan, ECM, CS and other county and community-based providers to support the management, maintenance, and sharing of member information that can be shared with other providers and organizations involved in each member's care.

Documentation systems may include certified electronic health record (EHR) technology or other tools that can support the documentation of:

- Member's enrollment into CS.
- Member's authorization/approval to release information to other providers and anyone involved in the member's care plan.
- Collecting social determinates of health (SDOH) data based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).
- Member's individualized CS assessments and goals/goal attainment status.
- Tracking and coordinating CS referrals to available community resources and following up to ensure services were rendered (closed-loop system).
- Information from other sources to identify member needs.

Documentation systems also need to be able to:

- Support the sharing of the member's assessment, individualized plan and other required data to the Plan, as requested.
- Assist with data sharing and reporting to the Plan as requested.
- Support and track the CS services provided to the member to enable CS providers to appropriately submit claims to the Plan.

A care management documentation system is not required to be a certified EHR technology, and it may include systems that are securely managed and hosted by third parties, including the Plan's partners.

12 Provision of CS Data Exchange

The Plan exchanges data with CS providers to allow CS providers to access member-level information, including authorization status, for all members referred by and/or assigned to their organization to receive CS services.

12.1 CS Data/Reports From the Plan to the CS Provider

The Plan will generate a Community Supports Authorization Status File (CSASF) for contracted CS providers that contains a cumulative list of both of the following:

- Members who have been assigned to that provider for service delivery.
- Members the CS provider referred to the Plan for authorization consideration (as applicable).

The Plan will provide all data elements defined by DCHS in the CalAIM Data Guidance: Community Supports Member Information Sharing Guidance. CS providers will receive these files bi-weekly on the 15th and 29th of every month.

12.2 CS Data/Reports From the CS Provider to the Plan

CS providers are responsible to submit required reports to the Plan. Required CS provider reports include but are not limited to the following:

- Monthly CS provider reporting: Community Support Provider Return Transmission File (CSPRTF). Providers must report back one time for both files and must be submitted between the 5th and 10th of the following month. If the provider missed the submission timeframe, CS providers will have to wait until the following month to resubmit.
- Quarterly submission of Staffing and Capacity Reports

12.3 Data and File Exchange Operations

On bi-weekly basis, CS providers must retrieve their CSASF via secure file transfer protocol (sFTP) site that contains “new potential member” that has been identified and assigned to the CS provider for outreach. CS providers will be responsible for collecting information on the member’s qualification and determine if the member truly qualifies for the service. Reference the Community Supports Authorization Guides to help determine the member’s eligibility for service.

On a minimum of a monthly basis, CS providers must update and report back to the Plan via an sFTP file upload of the CSPRTF, identifying the services provided and status of each eligible and enrolled CS member. Reporting requirements for CS providers has been defined by DHCS guidance.

13 Resources

CS providers can access multiple resources available online on the provider website.

- CalAIM Resources – Provides tools and resources to help providers easily navigate the CalAIM program. Providers will find the most current information on guides, forms, trainings and more.
- Provider Directory – View a list of contracted ECM and CS providers.
- Community Supports Authorization Guides – Helps determine member eligibility for DHCS pre-approved CS services.
- Community Supports Referral Forms – Use when requesting prior authorization for CS services.
- Claims and Invoice Procedure – Process for submitting a claim or an invoice.
- Frequently Asked Questions (FAQ) – Use this resource to answer questions you may have about referrals, authorization, billing, findhelp, housing deposit, provider portal and general questions regarding CalAIM.

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