Community Health Worker Provider Participation Application

Provider Type (check one)			
☐ Community-based organization (CBO)	☐ Hospital	☐ Individual licensed provider	☐ Outpatient clinic
☐ Local health jurisdiction	☐ Other (please indicate):		

Section 1: Provider Information					
Provider name:					
Tax ID:		NPI:			
Mailing address:	Street:				
City:		State:		Zip:	
County:					
Billing address: (if different)	Street:				
City:		State:		Zip:	
County:					
Phone number:		E-mail address:			
Fax number:		Contact name:			

Section 2: Required Documentation

****If there is a Medi-Cal enrollment pathway, you must first enroll through Provider Application and Validation for Enrollment (PAVE).** Submit documentation for ALL sections marked with "X" if you are a new provider. If you are expanding into new counties, skip sections 2 and 3 and complete sections 4 and 5.

State/Local Operating License(s) (please include current copies):			
Information required:	☒ Yes ☐ No		
☐ Business license	License #:	Expiration date:	
Certifications			
Information required:	☒ Yes ☐ No		
Is Provider Medi-Cal certified?	☐ Yes ☐ No	Medi-Cal number:	

Section 3: Insurance Requirements

Please submit documentation for ALL sections marked with "X". Skip this section if you are expanding counties.

Liability Insurance (please attach current certificate(s) of insurance)

Information required: ☒ Yes ☐ No

Please provide evidence of professional liability and comprehensive general liability insurance (see definition below) or self-funded insurance information. The following minimums must be adhered to by all facilities:

Health Net Minimum Malpractice Coverage	
General Liability: $1,000,000 per occurrence $3,000,000 in aggregate General liability insurance protects the assets of a business when it is sued for something that causes an injury or property damage.	**Professional (Malpractice):** **Ancillary** $1,000,000 per occurrence $3,000,000 in aggregate
Enter your general liability coverage amounts	**Enter your professional liability coverage amounts**

$ per occurrence
$ in aggregate
Carrier Name:
	$ per occurrence
	$ in aggregate
	Carrier Name:

Expiration Date:	Expiration Date:

Section 4: Community Health Worker (CHW) Employees by Service Area (counties)

Provide the number of active CHWs in each county your organization plans to contract for. If your organization provides services in Emergency Departments (ED), number of CHWs can be duplicative.

County	# of active CHWs	# of CHWs in ED settings	Engagement (in-person vs virtual)
Amador			☐ In-person ☐ Virtual
Calaveras			☐ In-person ☐ Virtual
Fresno			☐ In-person ☐ Virtual
Imperial			☐ In-person ☐ Virtual
Inyo			☐ In-person ☐ Virtual
Kings			☐ In-person ☐ Virtual
Los Angeles			☐ In-person ☐ Virtual
Madera			☐ In-person ☐ Virtual
Mono			☐ In-person ☐ Virtual
Sacramento			☐ In-person ☐ Virtual
San Joaquin			☐ In-person ☐ Virtual
Stanislaus			☐ In-person ☐ Virtual
Tulare			☐ In-person ☐ Virtual
Tuolumne			☐ In-person ☐ Virtual

Section 5: Existing Providers Expanding to New Counties

Complete this section **ONLY** if you are an existing CHW contractor.

Schedule Meeting

If existing CHW provider, have you consulted with your point of contact to determine gaps and needs for expansion request? ☐ Yes ☐ No

Capacity to Expand (*Input responses to all the questions in the text box.*)

The CHW provider will be required to submit responses to the questions and provide supporting documentation with the expansion request.

1. Complete Section 4.
2. Describe your experience and current relationship and/or partnerships in the county.
3. Describe your current outreach and engagement strategies to enroll members into the program.
4. Indicate how members can reach your organization or community health workers.
5. Based on your current staffing plan, describe your capacity and how you will be able to serve members in the new county.
6. Provide additional supporting documents for this expansion, as applicable.

Account Set-up

CHW provider has successfully set up their accounts and feels comfortable using the following platforms as required by the health plan.

- Provider portal: ☐ Yes ☐ No
- Can you submit claims? ☐ Yes ☐ No

Provider Utilization		
1. Have you received community referrals?	☐ Yes	☐ No
2. Do you have any utilization/authorizations?	☐ Yes	☐ No
3. Have you submitted any claims?	☐ Yes	☐ No
Note: Health plan will review utilization in your existing counties for expansion determination.		

Readiness to start the program (check applicable box):

☐ 0 to 60 days ☐ 60 to 90 days ☐ 90 to 120 days

Section 6: Demographic Questions for CHW Supervising Providers

1. What type of services from the list below does your CHW/Promotora (P)/Representative (R) workforce provide? Select all that apply.

   ☐ Cultural mediation among individuals, communities, and systems
   ☐ Health education and information
   ☐ Care coordination, case management or system navigation
   ☐ Social support
   ☐ Advocacy
   ☐ Capacity-building
   ☐ Direct service
   ☐ Individual and community assessments
   ☐ Outreach
   ☐ Evaluation and research
   ☐ Asthma prevention services
   ☐ Domestic violence prevention
   ☐ Refer to transitional care services, Enhanced Care Management, Community Supports, doula or other plan services
   ☐ Other (please specify): _____

2. Please select the type of population(s) that your CHW/P/R workforce serves. Select all that apply.

   ☐ Adults without dependent children/youth experiencing homelessness
   ☐ Individuals or families experiencing homelessness
   ☐ Individuals at risk for emergency department utilization
   ☐ Individuals with serious mental health and/or substance use disorders
   ☐ Individuals transitioning from incarceration
   ☐ Adults at risk for long term care institutionalization
   ☐ Adult nursing facility residents transitioning to the community
   ☐ Children enrolled in California Children's Services (CCS) or CCS Whole Child Model
   ☐ Children and youth involved in child welfare
   ☐ People with intellectual or developmental disabilities
   ☐ Pregnant and post-partum individuals
   ☐ School children
   ☐ Migrant and seasonal farmworkers and their families
   ☐ Older adults

☐ Immigrants
☐ LGBTQIA+ community
☐ People with disabilities
☐ Military veterans
☐ Other (please specify): _____

3. Please select all the areas your CHW/P/R workforce can support:

☐ Utilization of adult preventive care service
☐ Utilization of pediatric preventive care services
☐ Promotion of primary care engagement of unengaged members
☐ Support general care management services (non-complex case management, non-ECM)
☐ Support peripartum care
☐ Support utilization of transitional care services
☐ Support chronic disease management services
☐ Support utilization of behavioral health navigation services
☐ Support outreach for complex case management or ECM enrollment
☐ Support services which address social drivers of health
☐ Other services: If yes, list additional services below.

4. Please describe the racial and ethnic identities of the communities served by your CHW/P/R workforce.

5. Please describe the languages and/or dialects spoken by the communities served by your CHW/P/R workforce.

6. Please describe the racial and ethnic identities of your CHW/P/R workforce.

7. Please describe the languages and/or dialects spoken by your CHW/P/R workforce.

8. Total number of members the supervising provider has the capacity to serve (by county).

Section 7: Attestation Requirements

1. Community Health Worker requirements and qualifications attestation:

   As a supervising entity, we will adhere to the requirements in the CHW provider manual including, but not limited to: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/03BBA223-8762-4A94-A268-209510E15E37/chwprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

   ☐ Yes ☐ No ☐ N/A

2. Asthma Prevention Services requirement and qualifications attestation (if applicable):

   As a supervising entity, we will adhere to the requirements in the Asthma Preventive Services provider manual including, but not limited to: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B30BA13C-7A4F-47B9-9403-760091E44ADC/asthprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

   ☐ Yes ☐ No ☐ N/A

3. Readiness to start the program (check applicable box):

   ☐ 0 to 60 days ☐ 60 to 90 days ☐ 90 to 120 days