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| **Organization Name:** |  |

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| **Please respond to all of the questions listed below. Incomplete forms will be returned and cause a delay.** |

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| 1. The executive leadership at my organization has reviewed the DHCS APL 24-006   <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-006.pdf> | \_\_\_\_\_\_ | |
| 1. My organization has an administrative lead or manager identified to lead the implementation of this benefit. If yes, answer below:  |  |  | | --- | --- | | 1. Name: |  | | 1. Contact Information: |  | |  |  | | \_\_\_\_\_\_ | |
| 1. My organization has staff in place to provide the CHW/P/R services:  Fully staffed  Need to hire   *If your organization is* ***fully staffed****, please answer the following:*   1. Total number of CHW/P/Rs, including full-time and part-time positions in the organization  |  |  | | --- | --- | | Number of full-time staff: |  | | Number of part-time staff: |  |   *If your organization* ***needs to hire staff,*** *please answer the following:*   |  |  |  | | --- | --- | --- | | 1. Target hire date for new staff: |  | | | 1. Number of hired staff: | |  | | | |
| 1. My organization has a closed-loop referral system | \_\_\_\_\_\_ | |
| 1. My organization uses or has the ability to use electronic authorization (requests) processes. | \_\_\_\_\_\_ | |
| 1. My organization uses or has the ability to use a claims (payment) process, if yes, please mark box below:   Paper Claims (CMS-1500 Form)  Paper Claims (UB 04 Form)  Electronic Claims (EDI 837) | \_\_\_\_\_\_ | |
| 1. My organization is currently enrolled as a Medi-Cal provider? If no, please visit <https://www.dhcs.ca.gov/provgovpart/Documents/Enrollment-for-CBOs-LHJs-using-PAVE.pdf> | \_\_\_\_\_\_ | |
| 1. My organization is currently contracted with PHC for services, if yes, list all services below:  |  | | --- | |  | | \_\_\_\_\_\_ | |
| 1. My organization is a non-profit entity. | \_\_\_\_\_\_ | |
| 1. My organization has an NPI number.  |  |  | | --- | --- | | *If yes, list the NPI:* |  | | \_\_\_\_\_\_ | |
| 1. My organization has a federal EIN number.  |  |  | | --- | --- | | *If yes, list the EIN::* |  | | \_\_\_\_\_\_ | |
| 1. My organization is contracted with other commercial payers and/or other Medi-Cal payers | \_\_\_\_\_\_ | |
| **Additional Information:** | |

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| 1. Areas of Focus – select all that apply: |
| |  |  | | --- | --- | | 🞏 Unhoused or those experiencing Homelessness  🞏 Birth Equity | 🞏 Control and prevention of chronic conditions  🞏 Asthma Prevention | | 🞏 Youth and Children  🞏 Sexual and Reproductive Health | 🞏 Aging  🞏 Health Education to Promote Health | | 🞏 Violence Prevention  🞏 Respite Services | 🞏 Perinatal Health Conditions  🞏 Health Navigation | | 🞏 Mental Health Conditions | 🞏 Other: | | 🞏 Substance Use Conditions |  | | 🞏 Oral Health |  | |

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| **Do you delegate or subcontract to provide any of the services listed in the table above?**  **If yes, please list all service that are being delegated or subcontracted:** |
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| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1. Counties interested in serving, mark all that apply:  |  |  |  |  |  | | --- | --- | --- | --- | --- | | 🞏 Butte  🞏 Lake  🞏 Napa | 🞏 Colusa  🞏 Lassen  🞏 Nevada | 🞏 Del Norte  🞏 Marin  🞏 Placer | 🞏 Glenn  🞏 Mendocino  🞏 Plumas | 🞏 Humboldt  🞏 Modoc  🞏 Shasta | | 🞏 Sierra  🞏 Tehama | 🞏 Siskiyou  🞏 Trinity | 🞏 Solano  🞏 Yolo | 🞏 Sonoma  🞏 Yuba | 🞏 Sutter | | |

1. My organization has experience in working with the following community partners, mark all that apply:

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| 🞏 Primary Care Providers (PCPs)/Specialists  🞏 Hospitals or Emergency Rooms  🞏 Hospice/Palliative Care Agencies  🞏 County Based Programs and/or Services  🞏 U.S. Department of Veterans Affairs | 🞏 Medicare Benefits/Services  🞏 Kaiser  🞏 Partnership HealthPlan of California  🞏 Tribal Partners and/or Affiliated Agencies |

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| **Additional Comments or Information:** |
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