|  |  |
| --- | --- |
| **Organization Name:** |  |

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

|  |  |
| --- | --- |
| 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:** |

|  |
| --- |
| 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 |  |

 |

|  |
| --- |
| **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:** |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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:

|  |  |
| --- | --- |
| 🞏 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 |

|  |
| --- |
| **Additional Comments or Information:** |
|  |