Supervising Provider of Community Health Worker/P/Rs Provider Readiness Questionnaire

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

2. My organization has an administrative lead or manager identified to lead the implementation of this benefit. If yes, answer below: _____
   a. Name: _____
   b. Contact Information: _____

3. 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:*
   a. 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:*
   b. Target hire date for new staff: _____
   c. Number of hired staff: _____

4. My organization has a closed-loop referral system _____
5. My organization uses or has the ability to use electronic authorization (requests) processes. _____
6. 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)

7. 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
8. My organization is currently contracted with PHC for services, if yes, list all services below: _____

   _____
9. My organization is a non-profit entity. _____
10. My organization has an NPI number. _____

    If yes, list the NPI: _____
11. My organization has a federal EIN number. _____

    If yes, list the EIN: _____
12. My organization is contracted with other commercial payers and/or other Medi-Cal payers _____

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Additional Information:

13. Areas of Focus – select all that apply:

- ☐ Unhoused or those experiencing Homelessness
- ☐ Birth Equity
- ☐ Youth and Children
- ☐ Sexual and Reproductive Health
- ☐ Violence Prevention
- ☐ Respite Services
- ☐ Mental Health Conditions
- ☐ Substance Use Conditions
- ☐ Oral Health
- ☐ Control and prevention of chronic conditions
- ☐ Asthma Prevention
- ☐ Aging
- ☐ Health Education to Promote Health
- ☐ Perinatal Health Conditions
- ☐ Health Navigation
- ☐ Other: _____

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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14. Counties interested in serving, mark all that apply:

☐ Butte	☐ Colusa	☐ Del Norte	☐ Glenn	☐ Humboldt
☐ Lake	☐ Lassen	☐ Marin	☐ Mendocino	☐ Modoc
☐ Napa	☐ Nevada	☐ Placer	☐ Plumas	☐ Shasta
☐ Sierra	☐ Siskiyou	☐ Solano	☐ Sonoma	☐ Sutter
☐ Tehama	☐ Trinity	☐ Yolo	☐ Yuba	

15. 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: