2020 Quarter 1 Provider Packet
Provider Visit Form

Provider Name:_____ **Date of Visit:**_____

PCP____ Specialist____ CBAS____ Home Health____ SNF____ Ancillary____ Other____

PACKET INCLUDES:

- 2020 Quarter 1 Provider Visit Form
- Vendor Disclosure of Ownership Form
- Provider Demographic Attestation Form
- DHCS Timely Access Monitoring Survey
- Timely Access Standards
- Important Reminder about Claims and Requests for Medical Record Reviews
- Case Management Programs Referral Form
- Patient Health Education & Referral
- U.S. Preventative Services Task Force (USPSTF) A and B Recommendations Update
- Childhood Obesity Prevention and Treatment Provider Survey
- Diabetes Prevention Program Benefit
- New Maternal Mental Health Program
- "I Speak" Cards
- "Point to Your Language" Cards

☐ Accepting New Patients ☐ Accepting Existing Patients ☐ Not Accepting Patients

Comments: _____

_____

_____

Provider/Office Staff Signature: _____

Provider/Office Staff Print: _____

Vendor Disclosure of Ownership Form

I. Instructions

This form must be completed and submitted to Alameda Alliance for Health (Alliance) by all providers and subcontractors. A new Disclosure Form is required and must be submitted in the event of renewal or extension of the contract or within 35 days after any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management; and (2) exclusions of individuals and entities from government programs as set forth in your contract with the Alliance and the Alliance's administrative requirements.

The disclosure, reporting, and exclusion requirements apply to partnerships on both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties organized as corporations are required to complete all sections of this Disclosure Form. Counties that are not organized as corporations are only required to complete Sections II, III, and VI of the Disclosure Form. The definitions are based on law, regulation, and instructions from regulatory authorities.

Important Note: For the purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

- **(I) Officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and**
- **(II) Partners of a partnership, including without limitation limited liability partnerships.**

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definition of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
FEDERAL EMPLOYER ID (FEIN)	TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship	☐ Partnership	☐ Other Partnership (i.e., LP, LLP, LLLP)	☐ Limited Liability Co.
☐ For Profit Corporation	☐ Non-Profit Corporation	☐ Public Corporation	☐ State
☐ Incorporated County	☐ Unincorporated County (You may advance to Section VI for Certification)		☐ Other

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee** and **Person or Entity with an Ownership or Control Interest** in your business, and any Sub-Subcontractor in which you have direct or indirect ownership of 5% or more. All applicable fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided. A non-profit entity must disclose all required information applicable to the entity. Please review the definitions in Section VII.

No.	Full Legal Name and Title	Address Individuals – list home address Entities – list primary business address, every business location and P.O. Box	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1.					
2.					
3.					

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	SSN	Name of Person Related To	Related Person's SSN	Relationship
1.					
2.					
3.					

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in a disclosing entity other than that indicated in subsection IV (A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1.					
2.					
3.					

V. Excluded Individuals or Entities

A. Are there any of your employees, Persons or Entities with an Ownership or Control Interest in your business, or any of your Managing Employees, Affiliates, or Agents who are or have ever:

- Been excluded from participation in Medicare, any of the State health care programs, or Federal health care program under sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or any other state or jurisdiction since the inception of these programs?

☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

☐ Yes ☐ No

- Entered into a settlement in lieu of conviction involving fraud or abuse of any government program?

☐ Yes ☐ No

- Been debarred, suspended, or otherwise excluded for participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

☐ Yes ☐ No

B. Do you have any agreements for the provision of items or services related to the Alliance's obligations under its contracts with the State or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and the social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1.			
2.			
3.			
4.			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify the Alliance of any changes to this information as outlined in Section I.

NAME (print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed Disclosure Form to the Alliance as follows:

Please print single-sided and fax the completed form to the Alliance Provider Services Department:
Fax: **1.855.891.7257**

You may also mail the form to:
Alameda Alliance for Health
ATTN: Provider Services Department
1240 South Loop Road
Alameda, CA 94502

If you have any questions, please contact the Alliance Provider Services Department:
Phone Number: **1.510.747.4510**
Email: **deptproviderrelations@alamedaalliance.org**

VII. Definitions

For the purpose of this disclosure, the following definitions apply:

1. **Act** means the Social Security Act.

2. **Affiliate** means associated business concerns or individuals if, directly or indirectly:
   A) Either one controls or can control the other; or
   B) A third party controls or can control both.

3. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider or Subcontractor.

4. **Disclosing Entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. For purposes of this Disclosure Form, Disclosing Entity shall also include Provider, Other Disclosing Entity, Subcontractor, and Sub-Subcontractor.

5. **Other Disclosing Entity means** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

   A) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
   B) Any Medicare intermediary or carrier; and

C) Any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges, for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

6. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider or Subcontractor, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider or Subcontractor, or part thereof.

7. **Person or Entity with an Ownership or Control Interest** means a person or corporation that:
   A) Has an ownership interest, directly or indirectly, totaling 5% or more in the Provider or Subcontractor;
   B) Has a combination of direct and indirect ownership interests equal to 5% or more in the Provider or Subcontractor;
   C) Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider or Subcontractor, if that interest equals at least 5% of the value of the property or assets of the Provider or Subcontractor;
   D) Is an officer or director of Subcontractor or a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) Is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

8. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with the Alliance to provide health care services to Alliance members, including members enrolled through the Alliance's contracts with the State. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with the Alliance to members enrolled through the Alliances' government program contracts with the State, provided those services are significant and material to the Alliance's obligations under the respective government program contract.

9. **State** means the California Department of Health Care Services (DHCS).

10. **Subcontractor** means an individual, agency, or organization that has a contract with the Alliance that relates directly or indirectly to the performance of the Alliance's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Alliance.

11. **Sub-subcontractor** means:
   A) An individual, agency, or organization to which a Disclosing Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
   B) An individual, agency, or organization with which a fiscal agent or Disclosing Entity has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Provider Demographic Attestation Form

INSTRUCTIONS:

1. Please print clearly.
2. Please return form by fax to Alameda Alliance for Health (Alliance)
   Fax Number: **1.855.891.7257**

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

PROVIDER INFORMATION	
PROVIDER/CLINIC NAME	PROVIDER TAX ID
SITE ADDRESS	
MAIN PHONE NUMBER	FAX NUMBER
HOURS OF OPERATION	
CLINIC EMAIL ADDRESS	
LANGUAGES SPOKEN	ACCEPTING PATIENTS ☐ YES ☐ NO ☐ ONLY EXISTING

PROVIDER NAME	PROVIDER NPI	IS THIS PROVIDER STILL AFFILIATED WITH THIS PRACTICE?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Date Update Completed *(MM/DD/YYYY)*: _____ / _____ / _____

Notes:

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

C&O Reviewed 04/19

DHCS Timely Access Monitoring Survey

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have an important update that we would like to share with you.

The California Department of Health Care Services (DHCS) is conducting a quarterly monitoring survey of all Medi-Cal managed care health plans (MCPs) to assess provider compliance with appointment availability and wait time regulations.

About This Survey

Providers: In-network Alliance providers include PCPs, OB/GYNs, specialists, ancillary providers, and non-physician mental health (NPMH) providers.

Methodology: DHCS will call a randomized sample of network providers using the most recent provider data.

Questions: The survey solicits answers about the next three (3) available appointment dates and times for urgent and non-urgent for PCP, specialist, and NPMH; first prenatal; and non-urgent for ancillary services. Appointment dates and times are collected at the location level.

Survey may also include:

- Whether a specific provider is accepting new patients.
- What are the next appointment availabilities for new or existing patients?
- What are the next appointment availabilities for adult or pediatric patients?
- Inquiry about a specific provider's appointment availability at the location.
- What the office staff understands about a patient's request for interpreter services.
- Whether languages other than English are spoken at the location and by the specific provider.

The results of the surveys are shared with providers to identify opportunities for improvement.

Thank you for your attention and assistance in completing the DHCS timely access monitoring survey.

Please note, this survey is independent of any survey conducted by the Alliance.

Questions? Please contact the Alliance Quality Improvement Department
deptqualityimprovement@alamedaalliance.org
www.alamedaalliance.org

Timely Access Standards

Alameda Alliance for Health (Alliance) is committed to working with our provider network in offering our members the highest quality of health care services.

Timely access standards* are state mandated appointment timeframes for which you are evaluated.

All providers contracted with the Alliance are required to offer appointments within the following timeframes:

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
Initial OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
Initial OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
After-Hours Telephone Access – Provide 24 Hours Coverage	
Emergency Instructions – Ensure Proper Emergency Instructions	
Language Services – Provide 24 Hour Interpretive Services	

*** Per DMHC and DHCS Regulations PA = Prior Authorization**

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Important Reminder about Claims and Requests for Medical Record Reviews

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important reminder we would like to share with you.

In an effort to provide the best service for our members and meet our regulatory obligations, the Alliance Compliance Department periodically reviews claims data and medical records submitted on behalf of our members. Requests to our provider partners for medical records are a part of this effort, and the Alliance appreciates your cooperation. If you receive a request for medical records, we ask that you please provide the complete information in a timely manner.

We appreciate and thank you for the quality care that you provide to your patients and our community.

Questions? Please contact the Alliance Compliance Department
Email: **compliance.alamedaalliance.org**
www.alamedaalliance.org

Case Management Programs Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) member patients to our case management program.

INSTRUCTIONS

1. Please return the completed form via mail or fax:
   Alameda Alliance for Health
   Attn: Case and Disease Management Department
   1240 South Loop Road, Alameda, CA 94502
   Toll-Free: **1.877.251.9612 |** Fax: **1.510.747.4130**

NOTE: The Alliance will directly notify the member if they are selected for a case management program.

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

NAME: _____

FACILITY/CLINIC NAME: _____

PHONE NUMBER: _____ FAX NUMBER: _____

REFERRAL SOURCE: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other: _____

SECTION 2: ALLIANCE MEMBER INFORMATION

LAST NAME: _____ FIRST NAME: _____

ALLIANCE MEMBER ID #: _____ DATE OF BIRTH (MM/DD/YYYY): _____

PHONE NUMBER: _____ SEX: ☐ FEMALE ☐ MALE

ADDRESS *(or location i.e. under 5th Street bridge)*: _____

CITY: _____ STATE: _____ ZIP: _____

SECTION 3: REFERRAL INFORMATION

REASON FOR REFERRAL (***please attach supporting/clinical documents from the past 30 days***):
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567**.

Patient Health Education & Referral

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

Health education is an important part of primary care visits. As a provider, you are a critical and influential source of health information for your patients. When you conduct an Initial Health Assessment (IHA) or review a patient's Staying Health Assessment (SHA), you uncover the key concerns of your patients. The Alliance offers member patient handouts and program referrals that can enhance your ability to address these concerns. You can find details about the IHA and SHA on our website at: **www.alamedaalliance.org/providers/medical-management**.

Health Education Handouts
Looking for the right handout? Our handouts are in English, Chinese, Spanish, and Vietnamese, and cater to our members.

Topics include:

- Asthma
- Baby & Breastfeeding
- Diabetes
- Injury Prevention
- Healthy Weight
- Mental Health
- Parenting
- Pregnancy
- Quit Smoking
- Sexual Health
- Substance and Alcohol Addiction

Health Education Program Referrals
Could your patient benefit from a healthy lifestyle program? Tobacco cessation? Breastfeeding classes? Diabetes self-management? Our Provider Health Education Resource Directory lists programs available at no cost to our members. You can refer members directly, or fax us the Provider Wellness Request Form to make a request on behalf of your patient.

More Alliance resources can be found on our website at:
www.alamedaalliance.org/providers/health-education-and-wellness-resources

Thank you for all you do to improve the health and wellbeing of Alliance members!

Questions? Please call Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.6038**
Email: **livehealthy@alamedaalliance.org**
www.alamedaalliance.org

U.S. Preventive Services Task Force (USPSTF) A and B Recommendations Update

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important update we would like to share with you.

At the Alliance, we require that all network and delegated providers follow the most current Preventive Care Guidelines. For asymptomatic healthy adults and pregnant women, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) A and B Recommendations for providing clinical preventive services.

We are sharing this quarterly update to ensure that our provider community is aware of the most recent changes. Listed below are the changes from February to September 2019.

TOPIC	DESCRIPTION	GRADE	RELEASE DATE
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019*
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (*BRCA1/2)* gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	B	August 2019*
Breast cancer preventive medications	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	B	September 2019*
Hepatitis B screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.	A	July 2019*
HIV pre-exposure prophylaxis for the prevention of HIV infection	The USPSTF recommends that clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.	A	June 2019
HIV screening: adolescents and adults ages 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.	A	June 2019*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A	June 2019*

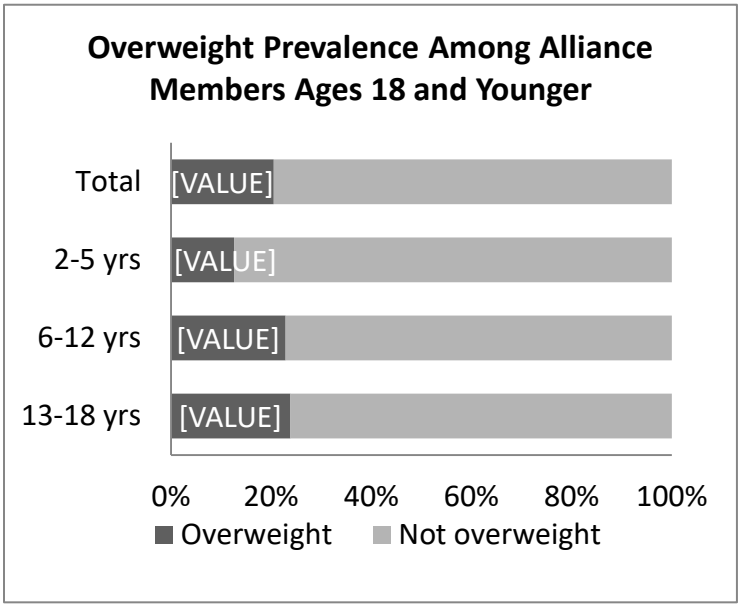
*Previous recommendation was an “A” or “B”

For a full list of USPSTF A and B Recommendations, please visit:
www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Childhood Obesity Prevention and Treatment Provider Survey

At Alameda Alliance for Health (Alliance), we value your perspective and knowledge as a provider who cares for Alliance members. We are interested in expanding our efforts to promote healthy weight for our youngest members.



Based on our data, we see that about one (1) out of every five (5) Alliance members ages 18 and younger are overweight. To learn more about how we can better support these children and their families, we are conducting a needs assessment. We want to know what is happening at the clinic level and how the Alliance can support these efforts.

You can help us by completing a short survey to tell us what you are currently doing to identify, prevent and/or treat childhood obesity and how the Alliance can better support your work. To access the online survey, please visit **https://bit.ly/2KJzJEh** (URL is case sensitive).

If you have any questions or would like to complete the survey by phone, please contact:

Jessica Jew, Health Education Specialist
Phone Number: **1.510.747.4577**
Email: **jjew@alamedalliance.org**

Thank you! We look forward to hearing from you.

Questions? Please call the Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

Diabetes Prevention Program Benefit

Alameda Alliance for Health (Alliance) is now offering the Diabetes Prevention Program (DPP) with our partner, Solera Health. DPP helps participants who are at risk for type 2 diabetes to adopt healthy habits and lose weight. This program is no cost for eligible members.

The program includes 16 weekly lessons, followed by monthly sessions for the rest of the year. The program follows a Centers for Disease Control and Prevention (CDC) approved curriculum. Members can choose from digital or in-person program formats.

To learn more about the program or how to refer patients please visit **www.alamedaalliance.org/providers/medical-management/dpp**.

You can also call Alliance Health Programs at **1.510.747.4577**.

Alliance members can enroll in DPP by:

1. Provider referral
2. Calling the **Alliance Member Services Department**
   Monday to Friday, 8 am – 5 pm
   Phone Number: **1.510.747.4567**
   Toll-Free: **1.877.932.2738**
   People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
3. Online at **www.alamedaalliance.org/live-healthy/dpp**

Questions? Please call the Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

New Maternal Mental Health Program

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have a new program that we would like to share with you.

The Alliance is excited to announce that our mental health provider, Beacon Health Options (Beacon), has created a new program to address maternal mental health. This program is designed to support perinatal women by linking them to behavioral health providers, community resources with an expertise in maternal mental health, and care coordination.

In California, one (1) out of every five (5) women have depression, anxiety, or both, while either pregnant or postpartum, with rates nearing 40% for low-income women. This can lead to decreased adherence to prenatal care, preterm delivery, issues with breastfeeding, increased risk of child abuse and neglect, and long term behavioral health risks for the child.

Providers can connect Alliance members to maternal mental health services:

1. **Screen** perinatal women for depression and other behavioral health concerns using PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS). Please remember to screen multiple times during pregnancy and postpartum.

2. **Refer** members to providers with expertise in perinatal depression/anxiety with a fax referral form on the Alliance website under the Behavioral Health tab at: **www.alamedaalliance.org/providers/resources**.

   Alliance members may also self-refer by calling Beacon toll-free at **1.855.856.0577**.

Beacon will match Alliance members with skilled providers in maternal mental health. They will also offer care coordination services as appropriate to ensure communication across physical health care, mental health, and substance misuse services.

Thank you for all you do to ensure your perinatal patients have the best of care and that concerns regarding maternal mental health are assessed and addressed early.

"I SPEAK" CARDS

FOR ALLIANCE MEMBERS

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

The Alliance has created "I Speak" cards as a resource for our provider partners and members to use during doctor visits. This resource includes information to help Alliance members get an interpreter for their health care visits. Alliance members can show the card to your office staff to let them know what language they speak. It also has instructions on how your office can contact the Alliance to get an interpreter.

Furthermore, you can help your patients if you are sending them to receive other services such as laboratory or radiology. The "I Speak" card will let the medical office staff know how to call an interpreter for your patient. Alliance telephonic interpreters are available 24 hours a day, 7 days a week at **1.510.809.3986**.

INSTRUCTIONS

1. Please fill in the member's preferred language.
2. Ask the patient to show the card to the health care provider for help in their language.

Please see back to view samples of the "I Speak" card.

To request a supply of "I Speak" cards, please email Alliance Health Programs at **livehealthy@alamedaalliance.org**. Please provide your name, clinic, mailing address, phone number, and quantity needed for each language. I speak cards are available in English, Chinese/English, Spanish/English and Vietnamese/English.

Thank you for partnering with us to ensure that our members are receiving care in their language!

ALAMEDA Alliance FOR HEALTH

Questions? Please call Alliance Health Programs
Monday - Friday, 8 am - 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

SAMPLES OF "I SPEAK" CARDS*

ENGLISH CARD - USE FOR ANY LANGUAGE

Front

ALAMEDA Alliance FOR HEALTH

I Speak: _____

PLEASE CALL AN INTERPRETER.
Thank You.

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

BILINGUAL CARD - AVAILABLE IN SPANISH, CHINESE AND VIETNAMESE

Front

ALAMEDA Alliance FOR HEALTH

I speak Spanish

PLEASE CALL AN INTERPRETER.
Thank you.

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

Inside

ALAMEDA Alliance FOR HEALTH

Yo hablo español

LLAME A UN INTÉRPRETE.
Gracias.

Proveedores: Para solicitar el servicio de interpretación por teléfono por encargo, llame al **1.510.809.3986**.

Los miembros de Alameda Alliance for Health (Alliance) pueden recibir servicios de interpretación para los servicios de cuidado de la salud cubiertos.

Tenga a la mano su número de identificación del miembro.

Miembros: Si tiene alguna pregunta, llame al Departamento de Servicios al Miembro de Alliance al **1.510.747.4567**.

*Actual "I Speak" Cards are standard business card size.

Point to your language. We will get you an interpreter.

Arabic اللغة العربية
أشر الى لغتك
وسنتادى المترجم حالا

Cambodian ភាសាខ្មែរ
សូមចង្អុលភាសារបស់អ្នក
យើងនឹងហៅអ្នកបកប្រែមកជូន

Cantonese 廣東話
請指認您的語言
以便為您請翻譯

Dari دری
شما به کدام زبان گپ می زنید؟
یک ترجمان می آید.

Eritrean ትግርና
ናብቃንቃኹም ኣመልክቱ
ኣተርጎሚ ክድወለሉ እዩ

Ethiopian አማርና
ወደቓንቓው ኣያመልክቱ
ኣስተርጓሚ ኣንጠራለን

Farsi فارسی
به زبانی که صحبت می کنید اشاره کنید،
برای شما مترجم می آوریم.

Hindi हिंदी
अपनी भाशा इशारे से दिखाइये ।
आपके लिए दुभाशिया बुलाया जाऐगा ।

Hmong Hmoob
Thov taw tes rau koj yam lus.
Peb yuav hu ib tug neeg txhais lus rau koj.

Indonesian Bahasa Indonesia
Tunjukkan bahasamu.
Jurubahasa akan disediakan.

Japanese 日本語
あなたの話す言語を指で、示してください。
通訳をお呼びします。

Korean 한국어
당신이 쓰는 말을 지적하세요.
통역관을 불러 드리겠어요.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້
ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້

Mam Mam
Yectz tyola.
K,o co jel yolon tejun xal toj tell tyola.

Mandarin 國語
請指認您的語言
以便為您請翻譯

Mien Mienh
Nuqv meih nyei waac mbuox yie liuz,
yie heuc faan waac mienh bun meih oc.

Pashto پښتو
خپله ژبه وښیه.
ژر به ترجمان درسره خبری وکړ.

Punjabi ਪੰਜਾਬੀ
ਅਪਣੀ ਬੋਲੀ ਇਸ਼ਾਰੇ ਨਾਲ ਦਸੋ ।
ਤੁਹਾਡੇ ਵਾਸਤੇ ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਬੁਲਾਇਆ ਜਾਏਗਾ ।

Russian Русский Язык
Укажите, на каком языке Вы говорите.
Сейчас Вам вызовут переводчика.

Spanish Español
Señale su idioma.
Se llamará a un intérprete.

Tagalog Tagalog
Ituro mo ang iyong wika.
Matatawagan ang tagapag-salin.

Thai ภาษาไทย
ช่วยชี้ให้เราดูหน่อยว่า ภาษาไหนเป็นภาษาที่ท่านพูด
แล้วเราจะจัดหาล่ามให้ท่าน

Urdu اردو
زبان مین بات کرنا پسند کرینگی؟ سی آپ کون
آپ کی مدد کیلے آپہی کی ترجمان کو بلایا جاہے گا.

Vietnamese Tiếng Việt
Chỉ rõ tiếng bạn nói.
Sẽ có một thông dịch viên nói chuyện với bạn ngay.

ALAMEDA
Alliance
FOR HEALTH