Community Health Worker (CHW) Services Benefit

The Alameda Alliance for Health (Alliance) Community Health Worker (CHW) Services Benefit–Care Plan Form must be completed by the CHW supervising organization in collaboration with the CHW who is providing the services and a licensed provider when providing a member with 12 or more units of CHW services. The form documents the member's health-related challenges and the plan for how CHW services will help mitigate these challenges.

What are CHW services?
CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health. CHWs provide services at no cost to qualifying Medi-Cal members. Starting in September 2022, the Alliance began covering CHW services for eligible members.

Who is eligible for CHW services?
Alliance members with Medi-Cal coverage and a CHW recommendation form completed by their primary care provider.

What is the purpose of the care plan?

- Pursuant to California Department of Health Care Services (DHCS) guidance, a Care Plan must be uploaded with a claim submission if a member receives 12 or more units of CHW services (or eight (8) or more units for Asthma Prevention) in a calendar year.
- The care plan must be written by one (1) or more individual licensed providers, which may include the referring provider and other licensed providers affiliated with the CHW supervising provider.
- CHWs may participate in developing the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other providers referenced in this section.
- The care plan may not exceed a period of one (1) year.
- The care plan must be reviewed at least every six (6) months.

Important Reminders:

- Members enrolled in Enhanced Care Management (ECM) are **excluded** from receiving CHW services as a benefit.
- CHW supervising providers are required to retain a copy of the Care Plan in the member's files.

For more information on this CHW Services benefit, refer to the DHCS website at **www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf**

Community Health Worker (CHW) Services Benefit – Care Plan Form

INSTRUCTIONS

1. Please print clearly or type responses in all the fields below.
2. Please upload the completed Care Plan with your claim submission if a member receives 12 or more units of CHW services (or eight (8) or more units for Asthma Prevention) in a calendar year.
3. Please retain a copy of the Care Plan in the member file.

For questions regarding this form, please email **chw@alamedaalliance.org**.

SECTION 1: CARE PLAN PROVIDER INFORMATION

Full Name: _____ NPI #: _____

Provider Office Name (if any): _____

Phone Number: _____ Fax Number: _____

Email: _____

License type(s) held by the provider (please select all that apply):

- ☐ Clinical Nurse Specialist (CNS)
- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Marriage & Family Therapist (LMFT)
- ☐ Licensed Midwife
- ☐ Licensed Professional Clinical Counselor
- ☐ Licensed Vocational Nurse (LVN)
- ☐ Nurse Midwife
- ☐ Nurse Practitioner (NP)
- ☐ Obstetrician/Gynecologist (OB/GYN)
- ☐ Practicing Physician Group (PPG)
- ☐ Physician Assistant (PA)
- ☐ Primary Care Provider (PCP)
- ☐ Psychologist
- ☐ Public Health Nurse
- ☐ Registered Nurse (RN)
- ☐ Other: _____

Please Note: The licensed practitioner who completed the Care Plan does not have to be enrolled in Medi-Cal or a network provider.

CHW INFORMATION

Last Name: _____ First Name: _____

CHW SUPERVISOR INFORMATION

Last Name: _____ First Name: _____

Organization Name: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Alliance Member ID #: _____

Medi-Cal/Client Identification Number (CIN): _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Other: _____

Race/Ethnicity (optional, please select all that apply):

- ☐ American Indian, Alaska Native, or Indigenous
- ☐ Asian, Asian American
- ☐ Black, African American, or African
- ☐ Hispanic, Latina/e/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other: _____

Language(s) **Spoken** (please select all that apply):

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Arabic
- ☐ Other: _____

Language(s) **Written** (please select all that apply):

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Arabic
- ☐ Other: _____

SECTION 3: HOUSING STATUS

Member's Housing Status (please select only one (1)):

- ☐ Housed
- ☐ Unhoused

If unhoused, please select the option that best describes the member's current reported housing status (please select only one (1)):

- ☐ Abandoned building/Place not meant for habitation
- ☐ Emergency shelter
- ☐ Street/Outdoors
- ☐ Tent
- ☐ Transitional housing
- ☐ Vehicle
- ☐ Other: _____

If the member is housed or has a mailing address, please provide:

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

SECTION 4: CARE PLAN

Definitions

Please complete the Care Plan following the provided definitions for each section:

- **Problem/Issue:** Specify the condition that the service is being ordered for and be relevant to the condition.
- **Treatment Staff:** Include a list of other health care professionals (name and job title) providing treatment for the condition or barrier.;
- **Barrier:** Specify barriers that may be preventing the member from goal completion.
- **Goals:** Objectives that specifically address the recipient's condition or barrier affecting their health.
- **Intervention:** List the specific services required for meeting the written objectives and include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

Care Plan Start Date: _____ Care Plan End Date: _____

PROBLEM/ISSUE 1

Problem/Issue:

Treatment Staff:

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Barrier:

Goal:

Intervention 1:

Intervention 2:

Intervention 3:

SECTION 4: CARE PLAN (CONT.)

PROBLEM/ISSUE 2

Problem/Issue:

Treatment Staff:

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Barrier:

Goal:

Intervention 1:

Intervention 2:

Intervention 3:

SECTION 4: CARE PLAN (CONT.)

PROBLEM/ISSUE 3

Problem/Issue:

Treatment Staff:

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Full Name: _____ Title: _____

Barrier:

Goal:

Intervention 1:

Intervention 2:

Intervention 3:

Please submit this Care Plan with your claims submission.