Community Health Worker (CHW) Services Benefit

The Alameda Alliance for Health (Alliance) Community Health Worker (CHW) Services Benefit - Recommendation Form must be completed by licensed providers who identify a member who may need and benefit from CHW services and recommend the member for CHW services. To access CHW services, members **must** have a written recommendation from a licensed provider. This form helps streamline the recommendation process for providers.

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. Effective September 2022, the Alliance will provide CHW services to 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.

Important Reminders:

- This form is ***not*** an authorization request.
- Please use the Alliance Community Health Worker (CHW) Services Benefit – Care Plan Form 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.
- 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 recommendation form in the member's files.

Community Health Worker (CHW) Services Benefit – Recommendation Form

INSTRUCTIONS

1. Please print clearly or type responses in all the fields below.
2. Please upload the completed Alliance Community Health Worker (CHW) Services Benefit – 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 this CHW Services Benefit – Recommendation Form, and the CHW Services Benefit – Care Plan (if applicable) in the member file.

For questions regarding this form, please email the Alliance CHW team at **chw@alamedaalliance.org**.

SECTION 1: RECOMMENDING 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)
- ☐ Physician Assistant (PA)
- ☐ Practicing Physician Group (PPG)
- ☐ Primary Care Provider (PCP)
- ☐ Psychologist
- ☐ Public Health Nurse
- ☐ Registered Nurse (RN)
- ☐ Other: _____

Please Note: CHW services require a written recommendation submitted by a provider who is a physician or other licensed practitioner of the healing arts acting within their scope of practice. The licensed practitioner does not have to be enrolled in Medi-Cal or a network provider.

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

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

Alliance Member ID #: _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

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: ELIGIBILITY CRITERIA

Please identify how the member is eligible for CHW services (please select all that apply):

- ☐ Diagnosis of one (1) or more chronic health (including behavioral health) conditions or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- ☐ Member expressed a need for support in health system navigation or resource coordination services.
- ☐ Need for recommended preventive services, including updated immunizations, annual dental visits, and well-childcare visits for children.
- ☐ One (1) or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six (6) months, or at risk of institutionalization.
- ☐ One (1) or more stays at a detox facility within the previous year.

SECTION 3: ELIGIBILITY CRITERIA (CONT.)

- ☐ One (1) or more visits to a hospital emergency department (ED) within the previous six (6) months.
- ☐ Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- ☐ Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels, or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- ☐ Results of a Social Determinants of Health (SDOH) screening indicate unmet health-related social needs, such as housing or food insecurity.
- ☐ Stressful life event presented via the Adverse Childhood Events screening.
- ☐ Two (2) or more missed medical appointments within the previous six (6) months.

SECTION 4: SUMMARY OF MEMBER ISSUE(S), NEED(S), AND CONCERN(S)

What is the member's issue(s), need(s), and/or concern(s)? (Please select all that apply)

- ☐ Advocacy
- ☐ Emotional support
- ☐ Health education
- ☐ Health navigation
- ☐ Linkage to community-based resources
- ☐ Non-medical support
- ☐ Physical support
- ☐ Other: _____

What specific topic(s) you would like CHW services to focus on? (Please select all that apply)

- ☐ Asthma
- ☐ Behavioral Health
- ☐ Children's Prevention Care
- ☐ Developmental Disability/Delay
- ☐ Diabetes
- ☐ Emergency Department (ED)
- ☐ Heart Disease
- ☐ Homelessness/Housing
- ☐ Justice Involved
- ☐ Maternal Health*
- ☐ Substance Use Disorder (SUD)
- ☐ Violence Prevention
- ☐ Other: _____

*If the member is pregnant/postpartum, or has experienced a miscarriage, stillbirth, or abortion, they may benefit from Doula Services available to Alliance members at no cost. For more information, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-resources**.

SECTION 5: SUMMARY OF MEMBER ISSUE(S), NEED(S), AND CONCERN(S)

Please provide any other information that may be helpful for the CHW to serve the member: