Community Health Worker (CHW) Organization Provider Credentialing Application

Thank you for your interest in joining the Central California Alliance for Health (the Alliance) provider network. We greatly value your partnership in better serving our community.

Enclosed is a CHW Credentialing Application and required supplemental forms.

Please complete the application and include a copy of general/professional liability coverage.

If any of the following apply to your organization, please include with this application:

- A copy of current business license.
- Disclosure of any history of liability claims in the past 7 years (if applicable).
- A copy of current State (Center for Medicare Services) site review (if applicable, not required).
- A copy of accreditation/certification (if applicable, not required).

DHCS Medi-Cal Provider Screening and Enrollment

Federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service program, if applicable.

For organizations with an existing state-level enrollment pathway: Use the DHCS standardized application form(s) to apply to participate in the DHCS Medi-Cal Program.

If your organization is a non-traditional provider type with no established credentialing pathway: The Alliance will verify the provider's credentials through credentialing in addition to any or all the following documents:

- Applicable business or professional license.
- IRS Form 990.
- Nonprofit status.
- Other documentation demonstrating official established business and/or individual entity.

All provider applications are reviewed by the Alliance Peer Review and Credentialing Committee or a Medical Director. Credentialing applications and supplemental documentation must be completed and signed within 180 days. Forms may be submitted in the following ways:

- **Email:** credentialing@ccah-alliance.org
- **Fax:** 831-430-5528

We appreciate your cooperation in the credentialing process.

Sincerely,
The Alliance Credentialing Department

Community Health Worker (CHW) Organization Provider Credentialing Application

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

CHW Areas of Focus (Please check all that apply):

- ☐ Preventive Services
- ☐ Health Education (coaching, goal setting)
- ☐ Cultural Liaison
- ☐ Support or advocacy to support a health condition or injury.
- ☐ Chronic Health Conditions
- ☐ Health Navigation
- ☐ Outreach/Coordination Screening for community services
- ☐ Violence prevention/safety
- ☐ Health-related Social Needs
- ☐ Connection to Community Resources
- ☐ Enrollment in government programs related to improving health
- ☐ Other (Please List): _____

CHW Populations of Focus (Please check all that apply):

- ☐ Pediatric Population
- ☐ Pediatric and Family Members of Pediatric Population
- ☐ Adolescent Population
- ☐ Female Population
- ☐ Seniors
- ☐ Male Population
- ☐ Mental Health Pediatric Specific
- ☐ Mental Health Adult Specific
- ☐ Specific Race/Ethnicity Focus (Please List): _____

Where will CHW services be provided?

- ☐ Member Home
- ☐ Non-Clinical Office Setting
- ☐ Clinic Setting (non-FQHC/RHC)
- ☐ Community Based Setting (streets, food pantry, community events, etc.)
- ☐ FQHC/RHC
- ☐ School

General Information

Name: _____

Doing Business As (DBA), if different than name: _____

Telephone Number: _____ Fax Number: _____

(Continued on next page)

Community Health Worker (CHW) Organization Provider Credentialing Application

Business Address:	City/State/Zip:
Email Address:	Website Address:
Office Contact Name:	
Phone:	Email:
Are you enrolled in Medi-Cal? Yes No	Are you enrolled in Medicare? Yes No

Do you have a National Provider Identifier (NPI)? Yes No

If yes, NPI:_____

Insurance Information

Name of General Liability Insurance Company: _____

Insurance Per Occurrence/Aggregate Amount: _____

Offices/Sites Where Members Will Be Served (if additional, please add to end of application)

Office/Site #1 Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Fax:_____ Email:_____

Website:_____ Location Hours:_____

Office/Site #2 Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Fax:_____ Email:_____

Website:_____ Location Hours:_____

Office/Site #3 Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Fax:_____ Email:_____

Website:_____ Location Hours:_____

Disclosure of any history of liability claims in the last 7 years

Does your organization have any liability claims within the last 7 years?

- ☐ No
- ☐ Yes. If yes, please provide a copy of any liability claims against your organization within the last 7 years.

I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR section 51000.30(a)(2)(B). I hereby affirm that the information submitted to Central California Alliance for Health (the Alliance) and any addenda thereto is true, current, and complete to the best of my knowledge and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Services Agreement.

Signature:_____

Title:_____

Date: _____

Community Health Worker (CHW) Organization Provider Credentialing Application

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

Individual CHW Staff

The Alliance may request additional information regarding individuals on this roster, if needed. Additional information regarding credentialing requirements are outlined in Policy 300-4040: Provider Professional Credentialing Criteria.

CHW Qualification Pathways (One of the below must apply)

- **Certification:** Please provide the name of the certification program and confirm field experience was included as a component of the certification program training.
- **Work Experience (2,000 hours):** For CHWs that fall within the Work Experience Pathway, these CHWs may provide CHW services without a certificate of completion for a maximum period of 18 months.
- **Violence Prevention:** A Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.

CHW Individuals					
Name Last, First	**Race/ Ethnicity**	**Date of Birth** DD/MM/YY	**Qualification Pathway:** (Certification, Work Experience or Violence Prevention)	**Certification Agency Name**	**Certification Completion Date** (Past or Future)

I certify that no CHW staff at our organization:

- ☐ Currently have their Medicaid billing privileges terminated for-cause or are excluded by a State Medicaid agency.
- ☐ Are currently excluded from any other Federal health care program.
- ☐ Have a history of fraud, waste and/or abuse.
- ☐ Have a recent history of criminal activity, including a history of criminal activities that endanger members and/or their families.
- ☐ Are currently debarred, suspended or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76.

For any boxes you are unable to check, please provide a detailed explanation on a separate sheet.

Signature:_____ Date:_____

Community Health Worker (CHW) Organization Provider Credentialing Application

The form below is a requirement of our Medi-Cal contract with the State. Please review and sign below where indicated.

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF DHS COMPUTER FILES FOR THE MEDI-CAL PROGRAM DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized / maintained by the Department of Health Services, I, (CBO name)_____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons and agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to the Plan, myself, my employees, fiscal agents, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

Signature of Provider:_____

Date:_____

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tiered Covered Transactions

By signing and submitting this certification as part of this proposal, the prospective lower tier participant is providing the certification set out below.

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances, including but not limited to suspension, debarment, or exclusion from participation in any federally funded health care program following its previous certification.
3. The terms *covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal*, and *voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
4. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
5. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to check the List of Parties Excluded from Federal Procurement and Non-procurement Programs.
7. Nothing contained in the foregoing shall be construed to require establishment of a system or records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is

proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

a. The prospective lower tier participant certifies, by submitting this proposal and signing below, that neither it or its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or is excluded as the result of state or federal action from participation in any federally funded health care program.
b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Signature:_____

Printed Name:_____

Date: _____

New Provider Training

As a new provider joining the Alliance, you are required to complete the Alliance new provider training.

After reviewing the information in the New Provider Training, please sign below to acknowledge that you have received these training materials and print the date of your review.

New Provider Training Non-PCP

I have completed my review of the new provider training materials from Central California Alliance for Health.

Signature of Provider: _____

Date: _____