



## Community Supports Provider Information Form

Please complete this form and email to CaHealthWellness\_ECM\_ILOS@cahealthwellness.com to express your interest in becoming a Community Supports (CS) provider. If you intend on servicing more than 5 counties, please utilize the online provider interest form.

### Request type (check all that applies)

New CS provider with our plan     Additional CS Services     Additional Counties

Provider type:

If "other", please indicate here: \_\_\_\_\_

### Business information

Company name: \_\_\_\_\_

Doing business as (DBA) name: \_\_\_\_\_

Tax ID number: \_\_\_\_\_ National provider identifier (NPI): \_\_\_\_\_

*If no NPI number exists, have you applied for one and date of doing so?* \_\_\_\_\_

### Business address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Fax number: \_\_\_\_\_

### Mailing address (if different)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Billing address (if different)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contract signatory name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Daily operations contact name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

**County Key**

Amador	Fresno	Kings	Nevada	San Bernardino	Sutter
Butte	Glenn	Los Angeles	Placer	San Diego	Tehama
Calaveras	Imperial	Madera	Plumas	San Joaquin	Tulare
Colusa	Inyo	Mariposa	Riverside	Sierra	Tuolumne
El Dorado	Kern	Mono	Sacramento	Stanislaus	Yuba

<b>Community Supports Service</b> (check all that applies)	<b>County:</b> Where the Community Supports service is offered (refer to the County Key above and list as applicable). <b>Capacity:</b> The number of members your organization can serve at time of implementation. <b># of FTE:</b> The number of employed full-time employees (FTEs).				
<input type="checkbox"/> Housing Transition Navigation	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Housing Deposits	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Housing Tenancy and Sustaining Services	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Short-term Post Hospitalization	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____

<input type="checkbox"/> Recuperative Care (Medical Respite)	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Day Habilitation Programs	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Nursing Facility Transition to Assisted Living such as RCFE and ARF	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Community Transition Services/Nursing Facility Transition Services to a Home	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Personal Care and Homemaker Services	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Environmental Accessibility Adaptations or Home Modifications	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____

<input type="checkbox"/> Medically Supportive Meals and Medically Tailored Meals	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Sobering Centers	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Asthma Remediation	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____
<input type="checkbox"/> Respite Services	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____	County: _____ Capacity: _____ Initial: _____ After 12 months: _____ # of FTE: _____

Please identify capacity limitations or other information you would like to share regarding your ability to provide service(s).

Please list all NPIs, addresses and counties that you will be servicing for CS

<b>NPI</b>	<b>Address</b>	<b>County</b>