Enhanced Care Management Provider Information Form

Please complete this form and email to CaHealthWellness_ECM_ILOS@cahealthwellness.com to express your interest in becoming an Enhanced Care Management (ECM) provider. If you intend on servicing more than 5 counties, please utilized the online provider interest form.

Request type (check all that applies)

☐New ECM provider with our plan ☐Additional population of focus ☐Additional counties

Provider type: Choose an item. Community-Based Organization (CBO)

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:_____

california health & wellness

County Key

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

Population of Focus (check all that applies)	**County:** Where the ECM service is offered (refer to the County Key above and list as applicable). **Initial Capacity:** The number of members your organization can serve at time of implementation. **Capacity after 12 Months**: Forecast the number of members your organization can serve 12 months after implementation. This does not be accurate, just an estimate would suffice. **# of FTE:** The number of employed full-time employees (FTEs).				
☐ Adult Experiencing Homelessness	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:_____
☐ Adult High Utilizer	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:_____
☐ Adult Serious Mental Illness or Substance Use Disorder	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:_____
☐ Adult Transitioning from Incarceration	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:_____

☐ Adult Long-Term Care Eligible At Risk for Institutionalization	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:_____
☐ Adult Nursing Facility Residents Transitioning to Community	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:_____
☐ Youth Experiencing Homelessness	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:_____
☐ Youth High Utilizer	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:_____
☐ Youth Serious Emotional Disturbance or Clinically High Risk for Psych or First Episode	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:_____
☐ Youth Enrolled in CCS or CCS Whole Child Model with Add Needs Beyond CCS Condition	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:_____

☐ Youth Involved in or with a History of Involvement in Child Welfare	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:_____
☐ Youth Transitioning from Incarceration	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 ECM

NPI	Address	County
