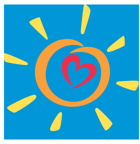


Community Health Worker Benefit Recommendation Form

Community Health Worker (CHW) benefit services are defined as preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotoras, community health representatives, community health liaison, community health coordinator, navigators, and other non-licensed public health workers, including violence prevention professionals. CHW services include health education, health navigation, non-clinical screenings and assessments, individual support or advocacy, and violence prevention services.

All requests for services can be submitted via Secure Email at (**CHWBenefit@lacare.org**) or via Secure Fax at **(213) 438-4863**. Incomplete recommendation forms will be returned to the recommendation source. This recommendation form is intended for L.A. Care Medi-Cal (MCLA) and DSNP members who receive their Medi-Cal benefits through MCLA ONLY.

This service is intended to offer support to individuals that are not otherwise connected to programs that offer similar services. If the member is connected to any case management program that provides support by Community Health Workers, then the member **DOES NOT** qualify to receive similar services through this benefit. Members who are connected to the following programs are excluded from this service as it is considered duplicative, with the exception of violence prevention services which are carved out from basic CHW services: Enhanced Care Management, Complex or High-Risk Care Management, or Hospice ONLY.

Please do not use this form for Kaiser Permanente, Blue Shield, Anthem, and non L.A. Care members.

Date of Recommendation: M M / D D / Y Y Y Y

Please make a selection of the type of services requested:

☐ Basic CHW Services ☐ Violence Prevention Services (Offered through L.A. Care contracted providers)

☐ Checking this box simply attests that the Member **IS NOT** receiving duplicative support from other State, local, or federally-funded programs.*

Please select how the member would like to receive services:

☐ In-Person Services ☐ Telephonic Services

Please select where the member would like to receive services:

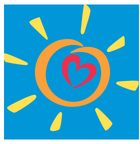
☐ Member would like to receive services from a contracted L.A. Care CHW provider. If you know the name of the provider, please list here: ______________________________

☐ Member has no service provider preference. L.A. Care will assign the member to one of our contracted providers.

☐ Please check this box if this Recommendation Form is being submitted on behalf of a member that you are currently serving and your organization would like to provide CHW services.

☐ Member would like to receive services from one of the L.A. Care Community Resource Centers.
(Please select one based on member's preference):

☐ Norwalk ☐ Long Beach ☐ Metro L.A. ☐ Palmdale ☐ Pomona ☐ Wilmington



Community Health Worker Benefit Recommendation Form

Recommending Provider Information

(Services require a written recommendation submitted by a physician or other licensed practitioner of the healing arts within their scope of practice, please check the type of license you hold)

☐ Clinical Nurse Specialist	☐ Licensed Vocational Nurse	☐ Physician Assistant
☐ Dentist	☐ LMFT	☐ Podiatrist
☐ LCSW	☐ MD/DO	☐ Psychologist
☐ Licensed Educational Psychologists	☐ Nurse Midwives	☐ Public Health Nurse
☐ Licensed Midwives	☐ Nurse Practitioner	☐ Registered Dental Hygienists
☐ Licensed Professional Clinical Counselor	☐ Pharmacists	☐ Registered Nurse

Recommending Provider's First Name:

Recommending Provider's Last Name:

Title:

Agency Name:

NPI #: 0 1 2 3 4 5 6 7 8 9

Phone Number:

Fax Number:

Email Address:

Member Information

Member's First Name:

Member's Last Name:

Gender: ☐ M ☐ F Other ________________

D.O.B.: M M / D D / Y Y Y Y

Age:

CIN: 0 1 2 3 4 5 6 7 8 9

LOB: ☐ Medi-Cal ☐ DSNP

Language Spoken:

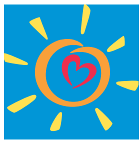
Language Written:

Current Mailing Address:

City:

Zip Code:

Phone Number:



Community Health Worker Benefit Recommendation Form

Basic CHW Eligibility Criteria:

The recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of **one** or more of the following (please check at least one criteria met below):

- ☐ Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- ☐ Presence of medical indicators of rising risk of chronic disease that indicate risk but do not yet warrant diagnosis of a chronic condition.
- ☐ Any stressful life event presented via the Adverse Childhood Events screening.
- ☐ Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- ☐ Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- ☐ One or more visits to a hospital emergency department (ED) within the previous six months.
- ☐ One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- ☐ One or more stays at a detox facility within the previous year.
- ☐ Two or more missed medical appointments within the previous six months.
- ☐ Member expressed need for support in health system navigation or resource coordination services.
- ☐ Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

CHW Violence Prevention Eligibility Criteria:

The recommending Provider must determine whether a Member meets eligibility criteria for CHW Violence Prevention services based on the presence of **one** or more of the following (please check at least one criteria met below):

- ☐ The Member has been violently injured as a result of community violence.
- ☐ The Member is at significant risk of experiencing violent injury as a result of community violence.
- ☐ The Member has experienced chronic exposure to community violence.

Clinical Information:

ICD-10-CM Diagnosis Codes: | | | | | | | | | | | | | | | | | | | | | | |

Summary of member issue(s), need(s), and concern(s):

Phone: 213.694.1250 Ext. 7254 Fax: 213.438.4863 Email: CHWBenefit@lacare.org