blue california
Promise Health Plan

Community Health Worker Benefit Extension Request Form

Licensed providers must submit requests for Community Health Worker (CHW) benefit extensions for services rendered to a member beyond four units daily or 12 units annually.

Extension requests should be submitted after 10 units of services have already been completed and a need for further services is indicated. An extension request must be approved prior to services being rendered beyond the annually allowed 12 units.

Licensed providers must submit requests for Asthma Preventive Services (APS) benefit extensions for service rendered beyond four units daily, two visits per year to a member.

Approved extension requests are valid for up to an additional six (6) or fewer months of services if services are no longer clinically indicated.

All request forms must be completed in full and submitted via Secure Fax to **(844) 742-1152**.

***Required fields**

Member Information			
Member name (first, last, middle initial if available)*:		Medi-Cal ID (CIN)*:	
Currently assigned CHW provider name (first, last, middle initial, if available)*:			
Date of extension request*:		Remaining units of service*:	
Please check the type of service extension being requested*: ☐ CHW basic services ☐ Violence prevention services ☐ Asthma preventive services			
Recommending Provider Information			
Provider name (first, last, middle initial, if available)*:		Licensed provider type (insert APL options)*:	
Organization name*:		Organization address*:	
Provider fax number*:	Provider phone number*:	Provider business email*:	Provider NPI*:
Attestation			
Did the member agree to an extension of services?* If no, do not proceed.			☐ Yes ☐ No
Is the member actively engaged in the plan of care?* If no, do not proceed.			☐ Yes ☐ No
Would the member benefit from a long-term care management program (e.g.: Enhanced care management (ECM), care management (CM), or hospice)? **If yes, must proceed with connecting the member to appropriate care**.			☐ Yes ☐ No
Care Plan			
Does the member have a continued need related to social determinants of health or a medical condition requiring continued support from a CHW that does not meet the criteria for any long-term care management program?* ☐ Yes: Please provide further details on page two. ☐ No: Do not continue with the extension request.			

Identified Need
At least one member need must be identified to receive additional services (select all that apply)*

Heath Navigation
- ☐ Member requires ongoing support related to their health situation, healthcare access, or health system navigation.
- ☐ Member requires support with new barriers to their health situation, healthcare access, or health system navigation.

Health education
- ☐ Member requires continued health education for an existing medical or behavioral health condition.
- ☐ Member requires health education for a newly diagnosed medical or behavioral health condition.
- ☐ Member requires health education due to recent increased risk for a chronic health condition.

Individual advocacy and support
- ☐ Member requires ongoing support in order to help prevent the onset of, or exacerbation of, a health condition.

Screening and assessment
- ☐ Member requires further screening and assessment to identify additional related social needs.
- ☐ Member requires ongoing resource connection and coordination support to address related social needs.
- ☐ Member requires resource connection and coordination support to address new health-related social needs.

Violence prevention services
- ☐ Member requires ongoing support related to existing violent injury due to community violence.
- ☐ Member requires ongoing support in order to help prevent injury or violence.
- ☐ Member requires violence prevention services as a result of a recently increased risk of experiencing violent injury due to community violence.

Asthma preventive services
- ☐ Member has asthma and would benefit from self-management education.
- ☐ Member has poorly controlled asthma and would benefit from an in-home environmental trigger assessment.

Is the member working with another healthcare professional to address the identified need?* ☐ Yes ☐ No

If yes, specify the provider name (first, last)*:	Specialty/license*:

Goal(s): How will the CHW support the member's identified need(s)?*

Objectives: What services or resources will help the member meet the identified goal (s)?*

Expected frequency/duration of services: Indicate the number of units and/or months the provider/CHW require to further support the member.*

Briefly explain why the member would benefit from continued services*