Community Health Worker (CHW) Provider Incentive Program Application

Please complete the information below to apply for the Community Health Worker Provider Incentive Program. Refer to the Frequently Asked Questions (FAQ) and APL 24-006 for additional information. For any questions regarding this program or to submit your completed application, please email CHW@iehp.org.

Submission of the CHW application is an attestation that the following requirements are met:

A. Sufficient experience providing similar services within the service area,
B. Ability to submit claims using standardized protocols,
C. Business licensing that meets industry standards,
D. Capability to comply with all reporting and oversight requirements,
E. No history of fraud, waste and/or abuse,
F. No recent history of criminal activity including a history of criminal activities that endanger Members and/or their families, and
G. No history of liability claims.

PROVIDER ENTITY INFORMATION

Entity Name: ________________________________

Entity Address: ________________________________

Entity City & Zip: ________________________________

Entity TIN: ________________________________

Contracted with IEHP: **Yes** **No**

Contact Person: ________________________________

Contact Phone #: ________________________________

Contact Email: ________________________________

Entity Classification: PCP CBO BH FQHC LHJ Other: ____________

Managed Care Accountably Set (MCAS) Measures of Focus: Select all the MCAS measures your entity's CHW can support:

- ☐ Child & Adolescent Well-Care Visits
- ☐ Well-Child Visits for the first 30 Months of life
- ☐ Immunizations for Adolescents-Combo 2
- ☐ Childhood Immunizations Status-Combo 10
- ☐ Lead Screening in Children
- ☐ Asthma Medication Ratio
- ☐ Controlling High Blood Pressure
- ☐ Hemoglobin A1c Control for Patients with Diabetes - HbA1c Control (<8%)
- ☐ Breast Cancer Screening
- ☐ Cervical Cancer Screening
- ☐ Chlamydia Screening in Women

CHW Request

Number of Requested CHWs (indicate selection): ___ **1** ___ **2**

Are your CHWs certified? ___**Yes** ___**No** ___**N/A**
If your employees are not certified, are you interested in obtaining certification ___ **Yes** ___ **No**

____ Provider Employed ___IEHP Employed

If 'Provider Employed' is selected, please answer the following:
Do you currently have CHWs on staff? ___**Yes** ___**No**
(Note: CHWs must be certified to implement the Provider Incentive Program)

FUNDING JUSTIFICATION

Please attach a detailed letter providing specific information and data to justify why these position(s) should be funded, including but not limited to case load of current providers at practice, work schedule/office hours, access times for appointments, etc.

Provider Name: ________________________________ **Date:** ________________________________

Provider Signature: ________________________________