KERN HEALTH SYSTEMS

PLEASE RETURN THIS CHECK-LIST WITH YOUR APPLICATION

COMMUNITY HEALTHCARE WORKER
APPLICATION CHECK-LIST

1. ☐ Section I. Personal Information
2. ☐ Section II. Education/Training/Experience
3. ☐ Section III. Current Employment or Volunteer Work
4. ☐ Section IV
   - ☐ Application Based on Certificate Pathway
     Attachments:
     - ☐ Course CHW Certificate of Completion or applicable license/certificate

   OR
   - ☐ Application Based on Experience
     Attachments:
     - ☐ Documentation of at least 2,000 hours work/volunteer experience in last 3-years
     - ☐ Certificate of Completion of CHW Course within 18-months
5. ☐ Section V. Attestation / Work Duties
6. ☐ Section VI. Application Signature & Date
7. ☐ Section VII. Supervising Provider Signature & date

NOTIFICATIONS:

- ***KEEP A COPY OF ALL MATERIALS SUBMITTED FOR YOUR RECORDS AS THE SUPERVISING PROVIDER MUST MAINTAIN EVIDENCE OF EXPERIENCE, MINIMUM QUALIFICATIONS, AND RELEVANT ANNUAL TRAINING.***
- ***CHW EMPLOYERS ARE RESPONSIBLE FOR VERIFICATION OF APPLICANTS' PERSONAL OR BACKGROUND INFORMATION.***
- ***YOU HAVE THE RIGHT TO REQUEST AND BE INFORMED ABOUT INFORMATION THAT KHS COLLECTS ABOUT YOU OTHER THAN PROTECTED BY PEER REVIEW LAWS. YOU ARE ENTITLED TO CORRECT ERRONEOUS INFORMATION UPON REQUEST. YOU ALSO HAVE THE RIGHT TO ASK THE STATUS OF YOUR APPLICATION.***

Mail, email or fax complete application to:

Mail to: Kern Health Systems Attn: PNM-Credentialing 2900 Buck Owens Blvd Bakersfield CA 93309	**Email to:** credentialing@khs-net.com **Fax to:** 661-473-7614

Section I. Personal Information
(Please *Print* or *Type* all information in ink)

Last Name | First Name | Middle Name

Home Address (Street Address) | Apt.# | City | State | Zip Code | County

Social Security Number | Mobile/Cell Phone

Date of Birth (Month/Day/Year) | **Gender:** ☐ **Female** ☐ **Male**

Email address | CHW NPI Number

Race/Ethnicity (Optional for Directory Purposes Only to help members make informed choice and to ensure our network is adequate to meet the needs of our members)

☐ **American Indian/Alaskan** ☐ **Asian** ☐ **Black/African American** ☐ **Hispanic/Latino** ☐ **White**

☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other (Specify)**

Language(s) used

English:	☐ **Speak**	☐ **Read**	☐ **Write**
Spanish:	☐ **Speak**	☐ **Read**	☐ **Write**
Other:	☐ **Speak**	☐ **Read**	☐ **Write**

Preferred Language for Correspondence: ☐ **English** ☐ **Spanish**

(Specify Other Language)

Section II. Education (United States or Other Country)

Highest Level of Education Completed (Check One)

☐ Elementary–12th Grade or General Education Development (GED)

☐ Some College/Jr College or Technical Degree

☐ College/University Degree

☐ Advanced Degree such as Master's or Doctoral

Other current State of CA Professional National or License / Certificate

Certificate Agency:

Certificate Number:

Section III. Current Employment or Volunteer Work as CHW

Name of Organization (Volunteer or Employment)

Address (Street address) | City | State | Zip Code | Phone #

Current Job Title | Work Start Date

Work Status: ☐ Full-Time ☐ Part-Time ☐ Volunteer

Section IV. Application based on completion of Certified Training Course (Fill out only if completed the CHW Certificate Course)

☐ I completed a CHW certification course.

Certificate programs must also include field experience as a requirement.

- Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
  - **CHW Certificate:** A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement.
  - **A CHW Certificate** allows a CHW to provide all covered CHW services described in APL 22-016, including violence prevention services.
  - **Violence Prevention Professional Certificate**: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute.7,8 A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

☐ Certificate Attached

Date training completed (MO / DY / YEAR)

Sponsoring Organization / Training Program

Instructor

☐ Distance Learning

Training Location (City)

OR Skip to Next Section if completing application based on Experience

Section IV. Application Based on Experience (Fill out only if applying based on Lived Experience)

☐ I completed the applicable work experience hours / Resume Attached

Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. ***A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.***

Date(s) of Experience: Start Date (Mo/Year) to- End Date (Mo/Year)

Name of Organization/ Agency

Applicant's Job Title

Name of Supervisor | Supervisor's Title | Supervisor's Telephone | Ext.

Agency's Street Address | City | State | Zip Code

At least 2000 hours of CHW service.
☐ Yes ☐ No

If no, how many hours?

Section V. Attestation / Work Duties

Describe what you do as a community health worker or promotor(a). Check all that apply

- ☐ **Communication**: Listen actively; communicate with empathy and gather information in a respectful manner; Speak and write in client's preferred language and at an appropriate literacy level; Document activities and services and prepare written documentation; Ensure language interpretation and access to translation services
- ☐ **Interpersonal/Relationship Building:** Establish relationships, and assist in individual and group conflict resolution; Recognize and appropriately respond to the beliefs, values, cultures, and languages of the population served; Provide informal counseling; Maintain confidentiality of client information and act within Health Insurance Portability and Accountability Act (HIPAA) requirements
- ☐ **Service Coordination & Navigation:** Identify and access resources; Help others navigate services and resources; Coordinate referrals and follow-up and track care and referral outcomes; Assess client needs using strength-based approaches
- ☐ **Capacity Building:** Identify problems and resources to encourage and help clients solve problems themselves; Collaborate with local partnerships to improve services, network and build community connections; Assess the strengths and needs of the community; Build leadership skills for yourself and others in the community
- ☐ **Advocacy:** Participate in organizing others, use existing resources and current data to help others promote a cause; Identify and work with advocacy groups; Stay abreast of structural and policy changes in the community and health and social service system; Speak up for individuals or communities to overcome intimidation and other barriers
- ☐ **Organizational Skills:** Plan and set individual and organization goals; Plan and set up presentations, educational/training sessions, workshops, and other activities; Effectively manage time and prioritize activities, yet stay flexible; Gather, document, and report on activities within legal and organization guidelines
- ☐ **Teaching/Education Skills:** Use methods that promote learning and positive behavior change; Use a variety of interactive teaching and coaching methods for different learning styles and ages; Plan and lead classes; Evaluate the success of an educational program and measure the progress of individual learners
- ☐ **Knowledge Based – Public Health Principles & Social Drives of Health:** Gain and share basic knowledge of the community, health and social services, specific health issues; Understand social determinants of health and health disparities; Stay current on health issues affecting clients and know where to find answers to difficult questions; Use and apply public health concepts

Section VI. CHW Application Signature

Please read the following statements carefully. Sign or type your name below to indicate your understanding and acceptance of these statements in the space provided.

- I certify that all the information provided by me in connection with this application is true and complete. I understand providing false or misleading information, material omissions or misrepresentations which is used in determining my qualifications may result in the voiding of the application and failure to be granted CHW network participation.
- I agree to abide by Kern Health Systems (KHS) Policy and Procedures, KHS provider service agreement, the Department of Health Care Services All Plan Letter 22-016, 42 CFR 440.130(c) and any subsequent updates, related to Community Health Worker Service Benefit.
- I certify and attest to having 3-years experience that aligns with and provides connection between the CHW services I provided and the member or population being served. I further give KHS permission to verify any information, work or volunteer experience, and references, which are important in determining my qualifications.
- I understand the application and supporting documentation submitted become the property of KHS and are non-returnable.
- I shall advise KHS PNM-Credentialing Department of my current address immediately, but no later than 10-days, of any changes of address or within 1-day of other significant changes in my work, volunteer status and/or certification.
- I understand Kern Health Services awards certification to community health workers with necessary skills and competencies based on completion of required training and/or relevant experience. Employers are responsible for verification of applicants' personal or background information.
- I acknowledge that this Application for Certification is not a contract between me and Kern Health Systems and does not make me an employee, agent, contractor, or representative of Kern Health Systems.

Signature **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**	**Date**

Section VII. Supervising Provider / Attestation & Acknowledgement

TO BE COMPLETED BY SUPERVISOR(S) LISTED IN SECTION III
Form must be submitted with Application

- I attest that as the Supervising Provider, I meet the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.
- I agree to ensure that the CHW meets the qualification listed in the KHS Policy and Procedures, KHS provider service agreement, the Department of Health Care Services All Plan Letter 22-016, 42 CFR 440.130(c) and any subsequent updates, related to Community Health Worker Service Benefit.
- I agree to oversee the CHW and the services delivered to KHS beneficiaries, and submit claims for services provided by the CHW.
- I understand as the Supervising Provider, I must maintain evidence of the CHWs education, minimum qualifications, training, and additional relevant training annually and will provide, upon request, to KHS Staff or DHCS Staff.
- I acknowledge responsibility for ensuring the provision of CHW services complies with all applicable requirements and will provide direct or indirect oversight to the CHW including but not limited to; guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable regulations.
- I understand Kern Health Services awards certification to community health workers with necessary skills and competencies based on completion of required training and/or relevant experience. Employers of the CHW are responsible for verification of applicants' personal or background information.
- I understand it is my responsibility to submit to KHS PNM-Credentialing Department all CHW Applications prior to any CHW initiating services to a KFHC Members; claims will be denied if services are rendered prior to receiving approval of the CHW or prior to receiving an official approval letter and effective date. I further understand my responsibility to notify KHS PNM Department of any changes to my practice, including changes to the CHWs providing services in my office including those who are no longer active, or who have significant changes in their work, volunteer status and/or certification immediately, but no later than 10-days of any changes.

Business Name:		**Business Tax ID:**	
CHW Provider Name:		**CHW Provider NPI:**	
Supervising Provider Name:		**Supervising Provider NPI:**	

Supervising Provider's Signature **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**	**Date**