Arizona Provider Enrollment – Provider Type CH Profile Form

PROVIDER TYPE PROFILE		
PROVIDE R TYPE	CH	COMMUNITY HEALTH WORKER ORGANIZATIONS

Effective Date: 02/16/2024	**Enrollment Type:** Atypical – FAO
Risk Level: High	**NPI Required:** No
Enrollment Fee Required: Yes	**Site Visit Required:** Yes
FCBC Required: Yes	

Description:

A Community Health Worker (CHW) organization is an organization who employs non-medical health workers who serve as liaisons for health and community service providers and enrollees to facilitate access to services and improve the quality of service delivery, including the coordination of services to improve medical and behavioral health outcomes.

CATEGORIES OF SERVICE		LICENSE/CERTIFICATION
MANDATORY	01 MEDICINE	● Each employee seeking reimbursement for CHW services from AHCCCS must hold an active voluntary certification to practice as a Certified Community Health Worker through the Arizona Department of Health Services (ADHS) ● Signed and dated Community Health Worker Organization Profile form ● Tribal Business License (*Required by each tribe if rendering services on Arizona Tribal Reservations)

As part of the application process, including the initial, revalidation and company change applications, the Owner/Provider is required to disclose each Employee/Driver's full legal name, employment begin date, employment end date (if applicable), date of birth, and social security number directly in the AHCCCS Provider Enrollment Portal (APEP). This requirement applies to any employee for which the CHW organization intends to seek reimbursement.

Any changes regarding the Employee/Driver must be reported within 30 days by submitting a modification in APEP.

ATTESTATION:
As the Owner/Provider, you attest through your signature below that all Employees seeking reimbursement for CHW services from AHCCCS hold valid, current ADHS Certification.

As the Owner/Provider, you further attest through your signature below to having a process in place to address any violation of state drug laws by an Employee and provide documentation upon request.

By signing below, you are also attesting through your signature that this information will be kept current, on file, and made available upon request to Arizona Health Care Cost Containment System (AHCCCS).

Signature		Printed Name	
Date			
Provider Name		Provider ID Number	

SPECIAL INSTRUCTIONS:

REVISED 02/16/2024