



BEST INTENTIONS

PEER SERVICES

WOMEN IN TRANSITION RE-ENTRY PROJECT INC.

COMMUNITY CARE PROGRAM • INTAKE, SCREENING & REFERRAL FORM

In clinical partnership with Yoshida, Yamada & Washington Services LLC (YYW)

ALL APPLICANTS MUST PROVIDE A COPY OF THE FRONT OF A CALIFORNIA ID / DRIVER'S LICENSE AND THE FRONT OF THE MEDI-CAL CARD (IF APPLICABLE).

Who completes this form: This intake may be completed by the participant (self-referral) or administered by a Community Health Worker (CHW), referring provider, or partner organization. Please complete every section that applies to the service(s) you are requesting below. Items marked (if applicable) may be skipped when they do not apply.

A SERVICES REQUESTED — select all that apply

- | | |
|--|---|
| ☐ Urban Ranch: Healing Walks — the “Healing Horse” Equine Therapy Program | ☐ Traditional Community Health Worker (CHW) Services |
| ☐ Medi-Cal Benefits Navigation & Enrollment Assistance | ☐ CHW Certification Course / Training Enrollment |
| ☐ Behavioral Health / Individual Therapy (Licensed Clinician) | ☐ Peer Support & Recovery Services |
| ☐ Other (please specify): | |



C3 CONSENSUS PROJECT — A NATIONAL FRAMEWORK FOR CHW PRACTICE

The National C3 Council defines a shared framework of 10 core roles and 11 core skills for Community Health Workers. Our CHW services and certification training are guided by C3 principles, including connection to the community served, cultural mediation, care coordination and system navigation, outreach, culturally appropriate health education, coaching and social support, advocacy, and building individual and community capacity. Scan or click to learn more.

C3 Council roles, competencies & resources (live)

<https://www.c3council.org/>

1 REFERRAL & REFERRING PARTY

Completed by:	☐ Participant (self-referral)	☐ Community Health Worker	☐ Referring Provider	☐ Partner / Other
Referral Date:		Date Received:		
Referring Program / Department or Name:		Referrer Name:		
Referrer Phone:		Referrer Email:		
Medi-Cal Managed Care Organization (MCO / Plan):				

2 PARTICIPANT INFORMATION

Participant Name (Last, First, MI):					
Date of Birth:		SSN (optional):		Phone:	
Email:		Preferred Name / Pronouns:			
Address or Best Place to Reach Participant:					
Best way to reach you:	☐ In person	☐ Phone call	☐ Text	☐ Email	☐ Mail
Best time to contact:		Leave voicemails?	☐ Yes ☐ No	May we text?	☐ Yes ☐ No
Preferred language:	☐ English	☐ Spanish	☐ Khmer	☐ Tagalog	☐ Vietnamese Other:
Secondary Contact (community) Name:		Relationship:		Phone:	
Client's Mother First / Maiden Name:		Number of Children (and ages):			
Family Reunification Case?	☐ Yes ☐ No	If yes, explain:			

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MEDI-CAL ELIGIBILITY CHECKPOINT — PLEASE READ BEFORE CONTINUING

Many services in this program — including Community Health Worker (CHW) visits, individual therapy, and Enhanced Care Management (ECM) — are delivered as Medi-Cal benefits. Before completing the Medi-Cal & Insurance section (Section 4), please confirm your Medi-Cal status below and follow the path that applies to you.

☐ I HAVE ACTIVE MEDI-CAL

Continue with this form.
Proceed to the next section and enter your Medi-Cal ID number in Section 4 (Medi-Cal & Insurance). Attach a copy of the front of your Medi-Cal card.

☐ I DO NOT HAVE MEDI-CAL

You have two options — see below.
You may apply for Medi-Cal now (recommended), or begin our free Community Care services first if you qualify. Either way, checking Medi-Cal eligibility is a condition of the program.

OPTION 1 — APPLY FOR MEDI-CAL NOW (RECOMMENDED)



Medi-Cal provides free or low-cost health coverage for eligible Californians. Scan the QR code or open the secure link below to apply online through BenefitsCal — California's official benefits portal. Most low-income residents qualify regardless of immigration status. Once enrolled, return to this form and complete the remaining sections.

Medi-Cal enrollment link (live):
<https://benefitscal.com/r/September2024>

OPTION 2 — BEGIN FREE COMMUNITY CARE NOW (IF YOU QUALIFY)

You do not need Medi-Cal to start. Our Community Care service provides up to six (6) therapy or support sessions at no cost to individuals who meet one or more of the following:

- Low-income individuals and families
- Military service members and veterans
- Survivors of domestic / intimate partner violence
- Individuals with limited means or no insurance

Program condition: Participants who begin services without Medi-Cal agree to check their Medi-Cal eligibility (Option 1 above) with the help of a Community Health Worker.

Note for Staff / CHWs:

CHW services (DHCS APL 24-006), individual therapy, and ECM require an active Medi-Cal ID for Medi-Cal billing. CHWs may assist participants with enrollment navigation as a billable Health Navigation service.

ABOUT US

The Community Care Program is operated by Women in Transition Re-Entry Project, Inc., doing business as Best Intentions Peer Services, in clinical partnership with Yoshida, Yamada & Washington Services LLC (YYW) — a Service-Disabled Veteran-Owned Small Business based in Long Beach, California.

Together, our peer-support and licensed-clinical teams deliver whole-person, community-based care to low-income individuals, veterans, survivors of domestic violence, justice-involved and re-entry populations, and others with limited means. As a Medi-Cal billing provider and an authorized Kaiser Permanente Southern California provider, we connect participants to Community Health Worker (CHW) services, behavioral health therapy, benefits navigation, peer support, and recovery services — meeting people where they are, in the communities they call home.

Contact: (562) 207-5564 • Management@BestIntentionsPeerServices.Org • 1401 E. 4th Street, Ste. B, Long Beach, CA 90802

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3 DEMOGRAPHICS

Race / Ethnicity (check all that apply):

- | | | |
|---|--|---|
| ☐ Hispanic / Latinx | ☐ African American | ☐ Asian |
| ☐ White | ☐ Bi-Racial | ☐ Middle Eastern / North African |
| ☐ Native Hawaiian, Guamanian, Samoan, Tongan, Other Pacific Islander | ☐ American Indian / Alaska Native | ☐ Other identified ethnicity or race |

Gender Identity:

- | | | | |
|------------------------------------|--|---|--|
| ☐ Male | ☐ Female | ☐ Trans Woman (MTF) | ☐ Trans Man (FTM) |
| ☐ Nonbinary | ☐ Prefer to self-define | ☐ Prefer not to answer | |

Veteran — served one (1) day or more in the U.S. Military?		☐ Yes	☐ No	☐ Prefer not to answer	☐ Unknown
ADA Considerations (physical / developmental / cognitive):					
Current Housing Status:	☐ Housed / stable	☐ At risk of homelessness	☐ Interim / SRO / shelter		
	☐ Unsheltered	☐ Transitional / re-entry			
Housing Needs (if applicable):					

4 MEDI-CAL & INSURANCE

Medi-Cal ID # (mandatory):		Medi-Cal Consent for Treatment (mandatory):		☐ Yes	☐ No
Other / Secondary Insurance:		Policy #:		Effective Date:	
Preferred Service Location — Service Planning Area(s) (select all that apply):		☐ SPA 1	☐ SPA 2	☐ SPA 3	☐ SPA 4
		☐ SPA 5	☐ SPA 6	☐ SPA 7	☐ SPA 8

5 JUSTICE-INVOLVED / RE-ENTRY INFORMATION (if applicable)

Supervision type (if applicable):

- | | | |
|---|--|--|
| ☐ Parole | ☐ PRCS / AB109 | ☐ Summary Probation (Court) |
| ☐ Formal Probation | ☐ Outside LA County | ☐ Other (specify below) |

CDCR #:		Probation #:		Release Date:	
Parole / Probation Agent (if applicable):		Agent Phone:		Agent Email:	
Facility (if applicable):		Other supervision (specify):			
PC 451 Arson: ☐ Yes ☐ No PC 290: ☐ Yes ☐ No Prior Arrests: ☐ Y ☐ N ☐ Unk Prior Convictions: ☐ Y ☐ N ☐ Unk					

6 REQUESTED ASSISTANCE & SERVICE NEEDS — check all that apply

- | | |
|--|--|
| ☐ Obtaining ID and/or other I-9 documents | ☐ Getting Medi-Cal, CalFresh (food stamps), General Relief, Veteran's Benefits, and/or SSI / Disability |
| ☐ Linkage to housing / shelter or interim housing (SRO) | ☐ Obtaining prescription medication or Medication-Assisted Treatment (MAT) |
| ☐ Linkage to health, mental health care, or Anti-Gambling Program (appointments, navigation, accompaniment, CHW training) | ☐ Specialty care or specific health needs (describe below) |
| ☐ Linkage to substance use disorder (SUD) treatment | ☐ Linkage to employment assistance / workforce development |
| ☐ Linkage to legal services | ☐ Transportation navigation (public / non-emergency medical transport) |

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Current Medication List:

Specialty care / specific health needs (describe):

Other requested assistance (describe):

7 CHW MEDI-CAL BENEFIT ELIGIBILITY SCREENING (DHCS APL 24-006)

Community Health Worker (CHW) services are a covered Medi-Cal preventive benefit (effective July 1, 2022; governed by APL 24-006). Effective April 2025, DHCS issued a statewide standing recommendation, so a Medi-Cal member who meets any eligibility criterion below may receive CHW services without first obtaining a separate licensed-provider recommendation. Eligible members may receive up to 6 hours (12 units) of CHW services per year. CHW services may not be billed concurrently with Enhanced Care Management (ECM) for the same member (duplicative).

Eligibility criteria — the member is enrolled in Medi-Cal and meets one or more of the following (check all that apply):

- ☐ Diagnosed with one or more chronic physical or behavioral health conditions
- ☐ Suspected mental health or substance use disorder
- ☐ Rising risk of chronic disease (e.g., elevated blood pressure or glucose)
- ☐ Experienced a stressful life event identified through ACEs screening
- ☐ Known risk factors: domestic / intimate partner violence, tobacco, alcohol, or drug misuse
- ☐ Screened positive for unmet health-related social needs (e.g., housing, food)
- ☐ One or more emergency department visits in the past 6 months
- ☐ One or more inpatient / psychiatric stays in past 6 months, or at risk of institutionalization
- ☐ Stay at a detoxification facility within the past year
- ☐ Missed two or more medical appointments in the past 6 months
- ☐ Expressed a need for help navigating the health system or coordinating resources

Covered CHW service categories the member may receive (APL 24-006):

- ☐ Health Education — health-topic information, instruction, and self-management support
- ☐ Health Navigation — referrals, system navigation, resource & benefits coordination
- ☐ Screening & Assessment — administering approved screenings and connecting to care
- ☐ Individual Support / Advocacy — peer support and advocacy to prevent worsening of conditions

Supervising Medi-Cal Provider / NPI (staff use):

Standing recommendation applied?

☐ Y ☐ N

8 BRIEF BEHAVIORAL HEALTH / CLINICAL SCREENING (Therapy track — if applicable)

Complete this section if requesting individual therapy or behavioral health services. May be completed with a Community Health Worker and reviewed by a licensed clinician.

Primary concern / reason for seeking services:

Duration: ☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6+ months

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Episodic

Severity: ☐ Mild ☐ Moderate ☐ Severe

Current symptoms (check all that apply):

- ☐ Anxiety
- ☐ Depressed mood
- ☐ Impulsivity
- ☐ Racing thoughts
- ☐ Appetite issues
- ☐ Excessive energy
- ☐ Irritability
- ☐ Sleep changes
- ☐ Avoidance
- ☐ Fatigue
- ☐ Loss of interest
- ☐ Suspiciousness
- ☐ Crying spells
- ☐ Guilt
- ☐ Panic attacks
- ☐ Trauma symptoms

Substance use (current or past — check all that apply):

- ☐ Alcohol
- ☐ Opioids
- ☐ Tobacco / nicotine
- ☐ Sedatives
- ☐ Cannabis
- ☐ None reported
- ☐ Stimulants
- ☐ Prior treatment

Brief safety screen (clinical):



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- ☐ No safety concerns reported at this time
- ☐ Reports thoughts of self-harm — staff to follow safety protocol
- ☐ Reports thoughts of harming others — staff to follow safety protocol
- ☐ Declined to answer

If any safety concern is endorsed, staff initiate the safety protocol and warm hand-off to a licensed clinician. National crisis support is available 24/7 by calling or texting 988 (Suicide & Crisis Lifeline).

**Current medications
(psychiatric / medical):**

Prior MH treatment / provider:

9 CHW CERTIFICATION COURSE / TRAINING ENROLLMENT (if applicable)

Complete this section to enroll in the WIT-BIPS Community Health Worker certification course. DHCS recognizes two qualification routes under APL 24-006: the Certificate Pathway (completion of an approved CHW certificate) and the Work Experience Pathway (at least 2,000 hours as a CHW within the prior three years, with certification earned within 18 months of the first billable CHW visit). CHWs are also expected to bring lived experience that connects them to the community served.

- ☐ I am interested in enrolling in the CHW Certification Course
- ☐ I am currently employed / volunteering as a CHW

Highest level of education completed:

Hours of CHW experience (approx.):

Intended qualification pathway:

☐ Certificate Pathway

☐ Work Experience Pathway

☐ Undecided / need guidance

Relevant lived experience (e.g., re-entry, recovery, military, housing, parenting):

Availability / preferred cohort:

☐ Weekdays

☐ Evenings

☐ Weekends

☐ In person

☐ Virtual

10 CONSENT, AUTHORIZATION & SIGNATURE

- ☐ Voluntary participation. I understand participation in the Community Care Program is voluntary and I may decline or withdraw at any time without affecting my eligibility for other care.
- ☐ Confidentiality & its limits. My information is kept confidential and shared only with my care team or as permitted by law. Information may be disclosed without my consent only where required (e.g., risk of serious harm to self or others, or suspected abuse of a child, elder, or dependent adult).
- ☐ Coordination of care. I authorize WIT-BIPS and YYW Services to coordinate my care and share necessary information with my CHW, treating providers, and Medi-Cal managed care plan to deliver and document services.
- ☐ Medi-Cal benefit acknowledgment. I understand CHW services are a Medi-Cal preventive benefit delivered under a supervising Medi-Cal provider, and that services are documented in my record as required by DHCS.
- ☐ Telehealth. I consent to receive services in person or via secure telehealth where appropriate.

Participant Signature

Date

Print Name

Community Health Worker / Staff Signature

Date

Print Name / Title

Supervising Provider Signature (if applicable)

Date

Print Name / Title

Return completed form to: WIT-BIPS Group Practice Manager · Management@BestIntentionsPeerServices.Org · (562) 207-5564. Attach a copy of the front of the participant's CA ID / Driver's License and the front of the Medi-Cal Card (if applicable).