MEDI-CAL COMMUNITY HEALTH WORKER (CHW) ANNUAL CONTINUING TRAINING CHECKLIST

Supervising providers, as defined in Medi-Cal policy, may use this checklist as a tool to track and document that a CHW under their supervision and for whom they intend to bill for services provided to Medi-Cal members has met the annual, continuing training requirement outlined in the Community Health Worker (CHW) Preventive Services section of the Medi-Cal Provider Manual, which is produced by the Department of Health Care Services (DHCS). When using this tool, please consider the following:

CHWs must complete a minimum of six (6) hours of additional training annually.

- Training should be in core competencies[1], as outlined in the Medi-Cal Provider Manual, and/or specialty areas.
- Supervising providers may provide and/or require additional training for subspecialty areas.
- Supervising providers are ultimately responsible for maintaining documentation of the CHW(s) under their supervision completing the annual continuing education requirements.

Note: This document is intended to be an optional tool for supervising providers and may be used to supplement documentation that an individual CHW satisfied Medi-Cal policy requirements. This document does not need to be submitted to DHCS but must be made available to DHCS upon request or in the event of a state or federal audit.

Section A – CHW and Supervising Provider Information

This section may be used to identify both CHW and supervising provider information.

☐ CHW Name/Title: _____

☐ Supervising Provider Name/Title: _____

☐ Supervising Provider Organization: _____

☐ Employment Start Date: _____

☐ Type of Employment (e.g., employee, contractor, volunteer) _____

Section B – Annual Continuing Training Requirement Tracker

This section may be used to document completion of the required, annual continuous training.

Training Topic	Brief Description	Hours	Date Competed	Supervising Provider Initials

(Add additional pages as needed)

Section C - Certification

This section may be used to certify that the information provided in the checklist is accurate.

☐ **Check this box**: I possess the requisite legal authority to submit this attestation on behalf of my organization. Further, I certify, under penalty of perjury, pursuant to applicable federal and state laws and as Medi-Cal policies, that all information provided in this attestation form is true, correct, and complete to the best of my knowledge and belief.

Name: _____ Title: _____

Email: _____ Phone: _____

Signature: _____ Date: _____