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## COMMUNITY HEALTH WORKER (CHW) SERVICE DOCUMENTATION

### Client Information

- Client Name: \_\_\_\_\_
- Medicaid ID #: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Address: \_\_\_\_\_
- Phone: \_\_\_\_\_
- Email: \_\_\_\_\_

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### Provider / Program Information

- CHW Name: \_\_\_\_\_
- CHW Certification: \_\_\_\_\_
- CHW NPI #: \_\_\_\_\_
- Billing Provider / Agency: POP SOLUTIONS
- CHAMPS Provider ID: 1306703467

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### Licensed Provider Recommendation

*(Required for Medicaid reimbursement)*

- Provider Type:  MD  DO  NP  PA  LCSW  Other \_\_\_\_\_
- Recommending Provider Name: \_\_\_\_\_
- Date of Recommendation: \_\_\_\_/\_\_\_\_/20\_\_\_\_
- Reason for CHW Services: \_\_\_\_\_

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*(e.g., care coordination, self-management education, social needs, access to care)*

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## Service Encounter Details

- **Date of Service:** \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_
  - **Location of Service:**  In-person  Community Center  Home
  - **Start Time:** \_\_\_\_\_ **End Time:** \_\_\_\_\_
  - **Total Time (minutes):** \_\_\_\_\_
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## Medicaid Billing Code

- **98960** – Individual education/training (1 patient)
  - **98961** – Group education (2–4 patients)
  - **98962** – Group education (5–8 patients)
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## Description of CHW Services Provided

*(Must clearly support the billed code)*

- Health education / self-management support
- Care coordination / navigation
- Social determinants of health support
- Referrals to medical, behavioral health, or social services
- Follow-up and advocacy

## Narrative Description:

## Client Needs Addressed

- Food assistance (SNAP/WIC)
  - Housing / utilities
  - Transportation
  - Employment / education
  - Health insurance
  - Mental health support
  - Other: \_\_\_\_\_
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## Outcomes / Progress Notes

- **Client response / progress:**
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- **Barriers identified:**
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## Referrals Made (if applicable)

- **Agency / Provider:** \_\_\_\_\_
  - **Reason:** \_\_\_\_\_
  - **Follow-up needed:**  Yes  No
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## Next Steps / Plan

## Attestation

I attest that the services documented above were personally provided, are accurate, medically appropriate, and meet Medicaid CHW service requirements.

- **CHW Signature:** \_\_\_\_\_
- **Date:** \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_

## Compliance Notes (Best Practice)

- Documentation must be completed on the same day or within 72 hours
- No physician signature required on each note
- Provider recommendation must be on file
- Retain records per Medicaid and funder retention rules