COMMUNITY CARE HEALTH

Small Group Implementation Questionnaire

Effective Date (mm/dd/yyyy) _____

Email questionnaire to your Community Care Health representative or your broker.

1: GROUP INFORMATION

Indicate how the group name should appear on billing statement _____

Indicate any DBAs for the group_____

2: ID CARDS

Where would you like initial identification cards mailed?

☐ Employee's residence (as indicated on Enrollment Application)

☐ Group (as indicated on Application for Group Benefit Agreement), not recommended

☐ Other _____

Where would you like maintenance identification cards (i.e., new hires) mailed?

☐ Employee's residence (as indicated on Enrollment Application)

☐ Group (as indicated on Application for Group Benefit Agreement), not recommended

☐ Other _____

3: DECISION MAKER

This individual will interface with Community Care Health for major decisions:

Name _____ Title _____

Street address_____ City _____State _____ Zip_____

Phone no. _____ Fax no. _____ Email _____

4: DESIGNATED HIPAA REPRESENTATIVE

This individual is authorized to receive and securely handle protected health information – not specific to individual HIPAA authorizations for claims:

Name _____ Title _____

Street address_____ City _____State _____ Zip_____

Phone no. _____ Fax no. _____ Email _____

5: GROUP ADMINISTRATOR

This individual will interface with Community Care Health on all non-billing related issues/service issues:

Name _____ Title _____

Street address_____ City _____State _____ Zip_____

Phone no. _____ Fax no. _____ Email _____

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Company name (please print) _____

6: PAYMENT INFORMATION

Payment Information – Select for initial and recurring payment options:

☐ **6A. Client submits payment to Community Care Health electronically to bank below:**

Bank name Wells Fargo

Account name Community Care Health

Transit routing no. 121000248 Account no. 4122337181

☐ **6B. Client submits payment to Community Care Health by mail to address below:**

Community Care Health
Attn: Accounting Dept
45 River Park Place, West, Suite 501
Fresno, CA 93720

7: COBRA ADMINISTRATION

The employer is responsible for COBRA administration. CCH does not offer federal COBRA administration support.

Cal-COBRA administered through CCH? ☐ Yes ☐ No

Please provide the following for your COBRA administrator.

Company name _____

Name _____ Title _____

Street address _____ City _____ State _____ Zip _____

Phone no. _____ Fax no. _____ Email _____

8: INITIAL ENROLLMENT

Standard method for initial enrollment:

☐ Census Tool: (Recommended. CCH will supply a customized excel document.)

☐ Employee Enrollment Form(s)

9: EMPLOYEE ASSISTANCE PROGRAM

Do you offer an Employee Assistance Program (EAP)? ☐ Yes ☐ No

EAP Provider: _____ Website: _____

Company name (please print)

_____

10: ADDITIONAL INFORMATION

Non-Community Care Health health plan employer contributions

If a non-Community Care Health (CCH) health plan is offered alongside CCH, the employer contribution for the non-CCH health plan is:
Employee: _____% Dependent: _____%

11: CERTIFICATION AND INDEMNIFICATION

The employer certifies and acknowledges that no attempt will be made to re-identify the individuals that are the subjects of the data provided as a result of a request for De-identified[1] or Summary Health Information.[2] In addition, the employer further certifies that it will require any downstream vendors or other parties that may receive De-identified and/or Summary Health Information at the request of the employer to certify that they will also make no attempt to re-identify the individuals that are subject to the data provided. Any attempt by a recipient to re-identify the data could constitute the use, disclosure, or maintenance of protected health information under HIPAA which would require recipient to meet all requirements for safeguarding protected health information and/or personal information set out in federal and/or state law. Recipient will indemnify and hold harmless Community Care Health and any Community Care Health affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any nonpermitted or prohibited use or disclosure of re-identified protected health information by recipient or any subcontractor, agent, person or entity under recipient's control.

12: CLIENT AUTHORIZATION

Date form submitted to Community Care Health:_____ First proposed enrollment meeting date:_____

Print name _____ Title _____

Authorized signature **X** _____ Date _____

1 De-identified Data has all 18 identifiers removed as required by HIPAA (§164.514) and that cannot be used alone or in combination with other information to re-identify individual(s) who are subjects of that data.
2 Summary Health Information summarizes claim data for an employer group to meet the requirements of De-identified Data that is aggregated to a five-digit ZIP code.