Vaya Health

Network Providers Application Form for Participation in the COVID-19 Cell Phone Program

On March 27, 2020, N.C. Governor Roy Cooper issued Executive Order No. 121, entitled "Stay at Home Order and Strategic Directions for North Carolina in Response to Increasing COVID-19 Cases". North Carolina's stay-at-home order was extended through May 8, 2020.

In an effort to support Vaya Health members who are most in need of accessing and connecting with our network providers for telephonic and telehealth services currently allowed by the Vaya Telemedicine Policy and NC Medicaid Clinical Coverage Policy 1-H during the COVID-19 pandemic, Vaya purchased a limited supply of cell phones that may be requested by our network providers for distribution to eligible members.

The primary purpose and use of this time-limited cell phone program is for providers to deliver medically necessary mental health, intellectual/developmental disability and/or substance use (MH/IDD/SU) services to our members who are currently unable to engage in such services because of a lack of a reliable communication device. Members who receive cell phones through this program may only use the cell phone to engage in telehealth/telemedicine services from Vaya providers and for other healthcare purposes, including, but not limited to, primary care, specialty care, dentistry, ophthalmology and pharmacy.

To qualify to receive a cell phone through a Network Provider approved by Vaya to participate in this program, the individual must:

A. Be a Vaya Health plan member whom the Network Provider reasonably believes will clinically benefit from medically necessary services being delivered through the use of a cell phone;
B. Currently receiving MH/IDD/SU services through a Vaya Network Provider;
C. Not have a phone or other communication device that could allow the individual to access telehealth and telephonic MH/IDD/SU services offered through their provider or other healthcare professionals (including another network provider);
D. Meet one or more of the following criteria: i) is discharged from a hospital inpatient unit within the last thirty (30) days; ii) has a twelve (12)-month or shorter history of high utilization of emergency services use; iii) is a participant of the Transitions to Community Living Initiative (TCLI); and/or iv) is likely to decompensate and require a behavioral health crisis intervention if the member does not receive at least one contact per week from their behavioral health professional.

If you are a Network Provider that currently serves any Vaya Health plan members who meet the above criteria, Vaya invites you to apply to receive one or more of the cell phones. We ask that you critically evaluate which members will be best served by this program in order to preserve a fair distribution to those members most in need. For each cell phone distributed by Vaya to a network provider under this program, Vaya will also pay the cost of the approved monthly service plan for a period of up to six months from the date service is activated on the cell phone.

By completing this application, you understand that there are a limited number of cell phones available for distribution, which will be distributed in Vaya's **sole** discretion.

PLEASE COMPLETE THE FOLLOWING INFORMATION				
Network Provider name:		**D/B/A name (if one):**		
Individual completing form (primary contact):			**Todays date:**	
Primary contact's email address:		**Primary contact's phone number:**		
Number of Vaya members who meet the above criteria for whom you are requesting phones:				
Eligibility criteria:	☐ Hospitalization	☐ Frequent ED use	☐ TCLI member	☐ At risk of decompensation
Reason(s) for cell phone request:				
What specific MH/IDD/SU services will be delivered using the cell phone?				
What is your anticipated frequency of using the cell phone to deliver MH/IDD/SU services to Vaya members served?				
How will services be provided if the cell phone(s) request is not fulfilled?				

By completing this form, I, on behalf of and as an authorized representative of, the following Network Provider, affirm the truthfulness, accuracy and completeness of the information that I provided in this application. I further agree, acknowledge, understand and accept that if Vaya approves my participation in this time-limited program, the Network Provider will be required to execute a contract amendment with Vaya Health prior to obtaining and distributing such cell phone(s).

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Network Provider printed name

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Network Provider signature and date

Submit your completed application form to the Vaya Health Provider Network Operations Department at provider.info@vayahealth.com.