MEMBER INCENTIVE (MI) PROGRAM

REQUEST FOR APPROVAL FORM

Member Incentive (MI) Programs *require DHCS approval* prior to implementation. Complete this form and email it to dental@dhcs.ca.gov.

Email subject line must include: DMC plan name, targeted disease/behavior, and incentive program name (if applicable). Submit 30 days prior to the desired start date. Incomplete forms will be returned to the submitter. For more information, see All Plan Letter 18-009.

SECTION 1:

A. DMC plan name: _____

B. Submission Date: _____

C. Contact Person: _____

Email: _____ Phone: _____

SECTION 2:

☐ New MI Program (Continue to section 3)

☐ Change to current MI Program **(Describe in detail the changes being made to the MI program in an attachment)**

SECTION 3:

Answer the following questions in an attachment.

1. Describe your MI program in detail.

2. What is the objective/purpose of the MI program?

3. What is the start date of the program?
4. What is the end date of the program?
5. Please describe the incentive(s) to be offered and how it will aid in obtaining the desired health outcome.

6. What is the monetary value of the incentive being offered?

7. How does a member sign up for the MI Program? Once signed up, how does the member participate in order to receive the incentive?

8. Will providers be notified of the MI Program? If yes, how will they be notified?

9. How will you verify that the member completed the required action?

10. How will you evaluate the incentive program?

DHCS SECTION ONLY

SECTION 4:

☐ Approved

Approved by: _____ Date: _____

☐ Denied

Denied by: _____ Date: _____

DHCS Comments: