Non-Emergency Medical Transportation Provider Application

Company Information

Legal Name of Service:		**DBA:**	
Corporate Street Address:		City:	
County:	State:	Zip Code:	Phone:
Fax:	E-mail:	Federal Tax ID Number (or SS# if sole proprietor)	

Mailing Address: (if different)		
City:	State:	Zip Code:

If multiple locations, please attach a separate list of all applicable service locations, addresses and contact information

1. **Names of contacts for your business:**

Name	Title	Phone	Email

2. **Please identify the types of service you provide AND the number of vehicles you use in regular service** (i.e., 7 Sedans, 2 Vans & 1 Para lift Van):

☐Sedans
☐Minivans
☐ Full Size Wheelchair (Para Lift) Vans
☐ Minivan with Paralift or Ramp
☐Ambulances
☐Stretchers
☐Other (please specify)

3. **Will your drivers assist ambulatory members if necessary** (i.e., frail and/or elderly patient)?

☐Yes ☐No **If yes**, indicate specific assistance: (check all that apply)

☐To/From Front Door ☐Up / Down Steps ☐In an Elevator ☐To a Check-In Desk.

4. Will your drivers assist riders as they transfer from a wheelchair seat?

☐Yes ☐No

5. If you use sedans, will you transport a person who is in a wheelchair, but who is capable of "scooting" from the chair to the vehicle and have the wheelchair folded up and placed in the trunk?

☐Yes ☐No (Note: This is not appropriate for van use because the stowed wheelchair can become a flying/harmful object within the vehicle in the event of a crash if it is not properly secured)

6. What is your present service area? Please give a detailed list of zip codes in which you would like to receive trips for pickup. Please list them <u>by county</u>, and include a separate sheet if needed.

Counties Served	Zip Codes Served within the County

7. Are you willing to accept van or para-lift trips outside of your local area if needs arise?

☐Yes
☐No

8. Are you willing to accept same day requests?
☐Yes
☐No

9. What are your regular business hours (when your office is open)?

Monday – Friday **Saturday** **Sundays/Holidays**

10. What are your days and hours of regular transportation service? (our system will not schedule a trip within one hour of start/stop time)

Monday – Friday **Saturday** **Sundays/Holidays**

11. What is the maximum number of daily round trips you are willing to accept within your service area?

Ambulatory **Wheelchair** **Other**

12. Will you agree to place a phone call to each rider informing them of pickup time, and confirm pickup Arrangements? ☐Yes ☐No

13. What is your primary communication system with vehicles/Drivers? Please check all that may apply:

☐ 2-Way Radio ☐ Cell Phone ☐ Other

14. Does your business qualify for your State's "Minority-Owned Business Enterprise" (**MBE**)?

☐ Yes

☐ No (Note: MBE usually means U.S. citizen(s), a sole proprietorship, partnership, corporation or joint venture, owned, operated and controlled by a minority group member or members who have at least 51 percent ownership. The minority group member(s) must have day-to-day operational and managerial control, and an interest in capital and earnings commensurate with his/her/their ownership. Minority is generally defined as belonging to one of the following racial minority groups: African Americans, Native Americans, and Hispanic Americans, Asian Americans or other similar racial groups.)

If yes, is your company a Certified MBE? ☐Yes ☐No

If so please provide us with a copy of your certificate.

If not, are you interested in becoming certified? ☐Yes ☐No

15. Does your business qualify for your state's "Women-Owned Business Enterprise" (**WBE**)?

☐Yes

☐No (designation not available in all states; description is above, replace "woman" for "minority.")

If yes, is your company a **Certified WBE?** ☐Yes ☐ No

If so please provide us with a copy of your certificate.

If not, are you interested in becoming certified? ☐ Yes ☐ No

16. What is your KMAP Medicaid provider number?

(**Mandatory** information if Medicaid provider number has been assigned to your company)

17. Insurance Information **Insurance Company** **Limit Amount per occurrence/aggregate $**

Vehicle Liability		
Personal Liability		
Workman's Comp		

NOTE: Attach insurance cover sheets or certificates of insurance to this application.

18. Have there ever been any liability (i.e., malpractice, commercial, or vehicle) claims, suits, judgments, settlements or arbitration proceedings brought against you or currently pending involving you?

☐Yes ☐No

19. Have you (or any employee that will provide services for us) ever been suspended, fined, disciplined, investigated, expelled, sanctioned or otherwise restricted or excluded from participation in any private, federal, or state health insurance programs (i.e., Medicare/ Medicaid), or are any such proceedings in progress against you/them?

☐Yes ☐No

20. Have you (or any employee that will provide services for us) ever been disciplined or sanctioned by any professional licensing body or accrediting organization, or are any such proceedings in progress against you/them?

☐Yes ☐No

21. Have you (or any employee that will provide services for us) ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions or duties of the services that will be provided or currently under Indictment or currently have pending any such charges?

☐Yes ☐No

22. Have you (or any employee that will provide services for us) ever been convicted of, pled guilty to, or pled nolo contrendere to any felony that alleged fraud, an act of violence, child abuse, patient abuse or sexual misconduct or are currently under indictment or currently have pending any such charges?

☐Yes ☐No

For any of these questions that you answered **Yes**, please provide a full and complete explanation on an additional sheet of paper. Answering **Yes** to any of the above questions does not necessarily disqualify you from consideration.

By signing this application, the Transportation Provider acknowledges that it, as well as any employee or contract employee, is not listed on the U.S. Department of Health and Human Services' Excluded Provider list for federal health care programs. Under no circumstances shall any such excluded provider be allowed to provide services in our Network.

APPLICANT'S SIGNATURE

The undersigned Provider certifies that the above information is true and complete. I further certify that the service specified above will operate in conformity to the requirements of all local, state, and federal regulations. The undersigned Provider hereby consents to its (including any of its principals or employees) background being checked by NEMT Vendor and/or its agent. Providers consents to the disclosure, inspection and copying of information and documents related to Provider's qualifications for Network participation by and between NEMT Vendor and other health care organizations and third parties regarding Provider's qualifications for the purpose of evaluating this application. Provider is informed and acknowledges that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications made in good faith in connection with evaluating the qualifications of health care providers. Provider hereby releases all persons and entities, including NEMT Vendor, their representatives and all persons and entities providing information to NEMT Vendor, from any liability they might incur for their acts and/or communications in connection with evaluation of Provider's qualifications for Network participation, including any decision to admit or deny Provider's application. Provider understands and agrees that Provider, as an applicant, has the burden of producing adequate information for proper evaluation of Provider's qualifications for Network membership. The undersigned hereby affirms that the information submitted in this application and any addenda thereto is true, current, correct, and completed to the best of my knowledge and belief and is furnished in good faith. Provider agrees to provide NEMT Vendor with any updated information in the event of any change in the information set forth in this application.

_____ _____

Applicant Signature ***Date***

<u>Required documents for Company Credentialing:</u>

☐ Copy of insurance coverage
☐ Copy of business license
☐ Copy of Disclosure of Ownership & copies of driver's licenses for all owners listed
☐ Company Drug Policy
☐ Vehicle Roster
☐ Vehicle Registration(s)
☐ If there is a local transportation requirement, provide a copy
☐ Is the provider a FTA Grant Recipient? ☐Yes ☐No

<u>Required documents for Driver Credentialing:</u>

☐ Copy of driver's license
☐ Copy of Hack license (if applicable)
☐ Copy of MVR (annually)

☐ Copy of Background Check (annually) – national and state
☐ Date of Pre-employment Drug Screen & annual drug screen – 10-panel screen, must list substances tested
☐Sex Offender Check
☐CTAA Pass Basic Training
☐Wheelchair Securement Training
☐First Aid Training
☐CPR Training
☐Defensive Driving Training