Transportation Information Request Form

The following information must be provided to process your enrollment application. Failure to submit required information may result in your application being returned to you and will delay the enrollment process. Attach additional sheets when necessary.

1. Are you an out of state provider of medical services interested in participation for one occurrence of care delivered to one beneficiary?

Yes☐ No ☐ If yes, indicate date of service: _____

If yes, do not continue completing this form, but you must sign the form on page 6.

2. Are you an out of state provider of medical services interested in participation for services to a beneficiary for a period up to a maximum of 60 days only?

Yes ☐ No ☐ Date of Service From _____ To _____

If yes, do not continue completing this form, but you must sign the form on page 6.

3. List the names of all other current or former companies or corporations owned or operated by any individuals listed in Section 1 of the Disclosure of Ownership and Control portion of your enrollment application, where the companies are or were Medicaid providers, Medicare providers, transportation providers, or providers of health care.

Company Name	FEIN or Provider Number	Owner(s) – include all owners
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. List the names of all other current or former companies or corporations owned or operated **by a spouse, parent, child or sibling** of any individuals listed in Section 1 of the Disclosure of Ownership and Control portion of your enrollment application, where the companies are or were Medicaid providers, Medicare providers, transportation providers, or providers of health care.

Company Name	FEIN/Provider #	Owner(s) – list relationship to Section 1 individual
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are there any other Medicaid providers at your service address?

Yes _____ No _____

If yes, list the provider names:

_____

_____

6. List any professional licenses held by the owners. List even if licensed outside of New York State.

Last Name, First Name	Lic # (State)	Profession	NPI or Medicaid Provider #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Do any of the owners operate a medical care institution (i.e. Nursing home, assisted living facility, etc.)? Yes _____ No _____

A. If yes:

Name of Facility	Type of Facility	Address	Provider #
_____	_____	_____	_____

B. Is the transportation cost included in their annual financial report to the Department of Health?

Yes _____ No _____

C. List categories of transportation that are included: _____

8. Indicate the estimated percentage of services you provide in the following categories:

_____% Confined to wheelchair ____ % Ambulating with assistance _____% Fully ambulatory

9. Which geographic area(s) are you certified to serve by the Department of Transportation?

_____

10. Indicate the exact days of the week and corresponding hours you provide transportation services:

Livery/Taxi _____

Ambulette _____

11. Estimate the percentage of business that will be billed to the NYS Medicaid Program: ____ %.

12. a. Identify the name, address and account number(s) of the bank(s) to be used by the business.

Name of Bank	Address	Account Number
_____	_____	_____
_____	_____	_____

b. Provide the names and social security numbers of all personnel authorized to sign corporate checks against those accounts:

Person(s) Authorized to Sign Checks	Social Security Number
_____	_____
_____	_____
_____	_____
_____	_____

13. Personnel

a. List all office personnel.

Last Name, First Name	Position	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. List all drivers.

Last Name, First Name	Hours worked per week	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Provide a history of past employment (5 years) for all owners, operation managers and office managers. (Use separate sheets of paper for each individual using the format below)

Name:

Position: (such as owners, office managers or operation managers. If owner serves as the office or operations manager, list accordingly.)

Name of Past Employer: (Name of company or individual)

Address: (Full address including phone number)

Employment Dates: (Start date to end date)

Nature of Duties: (Must be specific)

15. Required information regarding leasehold arrangements.

a. Business Location:

Indicate whether you rent or own the building at your service location. If you rent, indicate whether rent is paid in equal monthly or yearly installments. You must attach a signed copy of the current lease.

_____

Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

_____

Provide the name and address of the owner of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners, their social security numbers and any National Provider Identifiers or NYS Medicaid Program provider numbers or professional licenses held.

_____

_____

Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent canceled rent check.

_____

b. Garage Location: (if different)

Indicate whether you rent or own the building at your service location. If you rent, indicate whether rent is paid in equal monthly or yearly installments. You must attach a signed copy of the current lease.

_____

Submit a description of any other payments to be made as, or in lieu of, rent to the owner of the property.

_____

Provide the name and address of the owner of the building(s) to be used by the business. If a corporation or partnership, list the names of the officers, directors, principal stockholders, partners, their social security numbers and any National Provider Identifiers or NYS Medicaid Program provider numbers or professional licenses held.

_____

Provide the name and address to whom the rent is paid. Attach a copy (front and back) of the most recent canceled rent check.

_____

16a.) List the following information along with the vehicle identification number (VIN #) for each vehicle operated by (owned or leased) your company in the last year. Submit copies of the Registration and Insurance cards for each vehicle.

Vehicle Type	Seating Capacity	Model	Year	Owned/ Leased	VIN #	Company Leased To or From	Equipped with Wheelchair Lift/Tie Down

16b.) If you lease any vehicles, submit a copy of the lease agreement for each vehicle.

17. Does your company use subcontractors?

Yes ☐ No ☐

If yes, complete the following:

Name of Subcontractor	Vehicle Type	Seating Capacity	Model	Year	VIN #

18. Is your company a subcontractor for another medical transportation provider?

Yes ☐ No ☐

If yes, please provide the following:

Provider Name	NPI or NYS Medicaid Provider #
_____	_____
_____	_____

19. If this application is for a change of ownership or impending change of ownership, do you agree to pay all current and future liabilities that may be owed to the Medicaid Program by the entity that you have purchased or are purchasing as a result of an audit, investigation or other review?

Yes ☐ No ☐ Not an ownership change _____

If yes, please attach a separate signed statement to that effect. The statement must be signed by the owner (buyer) listed below. (Please note that in some cases, an applicant for enrollment of a currently enrolled ambulette company must agree to assume liabilities as a condition of enrollment.)

20. Please submit verification that all drivers are covered by Workmen's Compensation. If you have a waiver from Workman's Compensation, you may submit that instead.

Owner's Name (print): _____

Owner's Signature: _____ Date: _____

(Signature stamps are not permitted)

Application Prepared by (print): _____ Date: _____

Telephone Number: _____