

Vendor Application

Company Information

Legal Business Name	Doing Business As
Registered Owner of Company	
Street Address	
County	City
State	Zip Code
Federal Tax ID #	Non Profit, Tax Exempt #
Medicaid Provider #	

Contact Information

Phone Number	Fax Number
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Point of Contact

Name	Phone	Email	Title

Hours of Operation

What are your office hours?

What are your transportation service hours?

Can you accept rides after 4:00pm for the following day?

Service Area

Please list the counties you will provide service in.

Types of services you will provide and number of vehicles you will provide for each service.

<i>Taxi Cab</i>	<i>Med-Cars</i>	<i>Sedans</i>	<i>Minivans</i>	<i>Wheelchair Van</i>
<i>Mini Van with Wheelchair access</i>	<i>Multi-Passanger Bus</i>	<i>Multi Passanger Van</i>	<i>Stretcher</i>	<i>Ambulance</i>

Service Questions

1. Will your drivers assist ambulatory members is necessary?

Yes _____ No _____

Please mark all that apply.

Stairs	Elevator	Desk Check in	Front Door
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2. Will your drivers assist members in a wheelchair?

Yes _____ No _____

Please mark all that apply.

Stairs	Elevator	Desk Check in	Front Door
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3. Will your Drivers assist members from wheelchair to seat?

Yes _____ No _____

4. If your services provide sedans, will you transport a person who is in a wheelchair, but is capable of Moving from the Chair to the vehicle and have their Wheelchair folded up and placed in the back of the vehicle?

Yes _____ No _____

Will you contract with an organization that will provide attendants?

Yes _____ No _____

6. Will you provide child restraint seats?

Yes _____ No _____

7. Will you accept Van or Paralift trips outside of your service area?

Yes _____ No _____

8. Are you able and willing to accept same day request?

Yes _____ No _____

9. What is the maximum number of passengers you are willing to transport from the same location to the same destination? Will you charge Extra?

Yes _____ No _____ If Yes, Charge _____

10. What is the maximum number of *daily round trips* you are willing to accept in your service area? _____

11. What is your primary communications system with the vehicle drivers? Please list if there is more than one.

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12. Will you consider purchasing a form of communications if you do not currently provide them?

Yes _____ No _____

13. Does your business qualify for State’s “Minority- Owned Business Enterprise” MBE?

Yes _____ No _____

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

If yes, Please provide us with a copy of the certificate.

Insurance Information

Insurance Information	Company Name	Limit Amount Per occurrence/aggregate
General Liability		
Workman’s Comp		
Vehicle Liability		

Please attach insurance certificate of insurance to this application.

Signature

Date