BAY CITIES BROKERAGE

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

Point of Contact

Name	Phone	Email	Title

BAY CITIES BROKERAGE

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 services

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

Taxi Cab	*Med-Cars*	*Sedans*	*Minivans*	*Wheelchair Van*
Mini Van with Wheelchair access	*Multi-Passenger Bus*	*Multi Passenger Van*	*Stretcher*	*Ambulance*

Service Questions

1. Will your drivers assist ambulatory members if necessary?

Yes_____ No _____

Please mark all that apply.

Stairs	Elevator	Desk Check in	Front Door

BAY CITIES BROKERAGE

2. Will your drivers assist members in a wheelchair?

Yes_____ No _____

Please mark all that apply.

Stairs	Elevator	Desk Check in	Front Door

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_____

5. 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 Wheelchair Van or Para-lift 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_____

BAY CITIES BROKERAGE

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.

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