Transportation Application

Checklist

All required items (on the application checklist below) must be submitted with this application to be considered. If all required items are not submitted at time of application, this application will be denied.

- ☐ **Transportation Provider Application**
- ☐ **Attestation Form**
- ☐ **W-9 Form**
- ☐ **Copy of any applicable Certifications and/or Licenses**
- ☐ **Certificate of Liability Insurance –**
  - **General and Professional Liability (500,000/1,000,000 limits)**
  - **Worker's Compensation & Employer's Liability**
  - **Auto**

  Please contact your insurance agent to obtain a Certificate of Insurance form naming Community Care, Inc. (1801 Dolphin Drive, Waukesha, WI 53186) as a certificate holder.
- ☐ **Electronic Funds Transfer Form and a Voided Check**

COMMUNITY CARE, INC.

TRANSPORTATION PROVIDER APPLICATION

I. PROVIDER CONTACT INFORMATION

Provider Name: _____

Mailing Address

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Business Address **Same as Mailing Address Above** ☐

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Provider Contact Name: _____

Provider Contact E-Mail: _____

Signer Name and Title: _____

Website: _____

II. GENERAL INFORMATION

a. Servicing Area(s):

All Wisconsin Counties	☐	Outagamie	☐
Calumet	☐	Racine	☐
Dane	☐	Sheboygan	☐
Fond du Lac	☐	Walworth	☐
Kenosha	☐	Washington	☐
Manitowoc	☐	Waukesha	☐
Milwaukee	☐	Waupaca	☐
Ozaukee	☐	Winnebago	☐

Other: _____

- Target Group Selection:

  Please select the population you serve.

  Physically Disabled (**PD**) ☐

  Developmentally Disabled (**DD**) ☐

  Frail Elderly (**FE**) ☐

  All (**PD, DD, FE**) ☐

  Other: _____

- Hours of Operation:

  24 Hour Facility Yes ☐ No ☐

  List Hours

  Weekdays (Mon – Fri)

  Weekends (Sat – Sun)

Please check the holidays your organization will transport:			
	New Years Day		Labor Day
	Easter		Thanksgiving
	Memorial Day		Christmas
	Fourth of July		

III. SERVICES AND PROCEDURES OFFERED

Please place a check mark next to the corresponding service(s).

SERVICES		CHECK SERVICE YOU PROVIDE
Transportation: Select Medicaid covered (i.e. Medicaid covered transportation except ambulance & transportation by common carrier)		☐
Transportation: Non-Medicaid covered		☐

IV. PROVIDER ACCESSIBILITY AND AVAILABILITY

TDD/TTY Number ☐ Yes ☐ No If yes, specify: _____
Handicapped accessible ☐ Yes ☐ No
Sign Language ☐ Yes ☐ No

Experience in handling clients with Cognitive Disabilities, Developmental Disabilities and Physical Disabilities. Yes ☐ No ☐

List fluent languages spoken (other than English):

_____

V. SPECIALIZED EXPERTISE OFFERED BY YOUR AGENCY

Please check below any specialized expertise or unique services offered by your agency.

	Advanced Aged		Bariatric – 500 lbs. or more
	Developmentally Disabled		Bariatric – under 500 lbs.
	Physically Disabled		RN on staff
	Alcohol/Drug Dependent		Vent Care
	Emotionally Disturbed/Mental Illness		Wound Care
	Terminally Ill		Memory Care
	Correctional Clients		Bathing Services
	Irreversible Dementia/Alzheimer's		Diabetic Expertise
	Traumatic Brain Injury		

VI. LENGTH OF TIME IN BUSINESS

Please indicate the length of time the agency has been in business ***providing the services for which you are applying.***

_____ **Years** _____ **Months**

VII. CULTURAL COMPETENCIES

Please indicate the cultural composition of your organization by checking all that apply:

Does your agency perform Cultural Competency Training ☐ Yes ☐ No

Minority/Disadvantaged Provider:

☐ **At least 51% of the Board of Directors is minorities/women.**

☐ **The organization is owned and operated by at least 51% minorities/women.**

VIII. INELIGIBLE ORGANIZATIONS

The CMO shall exclude from participation in the CMO all organizations, which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. **Ineligibility**
   Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:
   a. Been convicted of the following crimes:
      i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);
      ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);
      iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);
      iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or,
      v. Offenses relating to controlled substances, i.e., conviction of a State of Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).
   b. Been Excluded from Participation in Medicare or a State Health Care Program. AState health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.
   c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards.
   (See Section 1128(b)(8)(B)(ii) of the Act).

IX. ORGANIZATION STRUCTURE

Please indicate your **organization structure** as reported on your federal income tax returns:

☐ **Corporation** ☐ **Limited Liability Corporation**

☐ **Partnership** ☐ **Sole Proprietor**

X. AGENCY OFFICERS/RESPONSIBLE PARTY

Please list the responsible person's name and telephone number for each agency position listed. If your agency has no such position, please indicate "N/A" for "not applicable".

Position	**Name**	**Telephone Number**
Executive Director/President:		
Chief Financial Officer:		
Chief Information Technology Officer:		
Human Resources/Personnel Director:		
Direct Service Delivery/Client Care:		

XI. GOVERNANCE

Does your agency have a Board of Directors? ☐ Yes ☐ No

If yes, how many members on the Board? _____

How often does your Board of Directors meet? _____

Are Board members paid or do they serve voluntarily? _____

Name and Telephone Number of Board Chair: _____

Name and Telephone Number of Vice Chair: _____

XII. LICENSE AND CERTIFICATION REQUIREMENTS

Please attach a copy of all licenses or certifications that relate to services you wish to provide: List licenses/certifications in space below. Some examples are listed below.

☐ **Transportation License**

☐ **Other:** _____

XIII. CLIENT DATA AND RECORDKEEPING

Is each business location HIPAA compliant? ☐ Yes ☐ No
If no, please explain:

_____

_____

XIV. FISCAL MANAGEMENT

EIN/SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER _____

Agency Accountant/Bookkeeper Name: _____

Phone Number: _____

Agency's External CPA/Auditing Firm Name: _____

Address: _____

Telephone Number: _____

BILLING/PAYEE INFORMATION

Provider Billing Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Billing Contact Name: _____

Billing Contact Phone and Fax Numbers: _____ _____

COMMUNITY CARE
VEHICLE INFORMATION CHART

Name – Company	Address – Company (Street, City, State, and Zip Code)	Wisconsin Medicaid Provider Number (eight digits)

Vehicle Identification	License Plate Number	Registration Date (MM/DD/YY)	Vehicle Year (YYYY)	Vehicle Make	Vehicle Model	Ramp (Yes/No)	Lift (Yes/No)	Cot / Stretcher (Yes/No)
1.								
2.								
3.								
4.								
5.								
6.								

Name(s) – Assigned Driver(s) or Mechanic(s) Completing Vehicle Inspections	Day of Week Inspections Are Completed	Name(s) – Assigned Driver(s) or Mechanic(s) Completing Vehicle Inspections	Day of Week Inspections Are Completed
1.		3.	
2.		4.	

I affirm that the vehicles listed on this form meet HFS 107.23 and 105.39, Wis. Admin. Code, requirements for a human services vehicle serving the disabled and elderly.

SIGNATURE – Person Completing Form	Name – Person Completing Form (print)	Job Title	Date Signed

- **Electronic signature is considered valid only when document is submitted by e-mail from the signer's e-mail address.**
- **If mailing or faxing application, signature must be handwritten.**

Revised: 02/07/20

COMMUNITY CARE, INC.
PROVIDER ASSURANCES AND CERTIFICATIONS

I _____ agree that all information included in this application is true and correct and that the provider understands and agrees to the application information and requirements. Provider further acknowledges that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from receiving public (MCO) funds and legal action or fiscal sanctions may be taken as determined appropriate by Community Care, Inc. or its designated representative(s). Provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the MCO.

I _____ constitute as the Provider to allow authorized representatives of Community Care, Inc. funding sources to have access to all records necessary to confirm the provision of services by the Provider. Failure on the part of the Provider to comply with program requirements or not have sufficient documentation to verify provision of the services billed may result in withholding or forfeiture of any payments. At a minimum, the Providers must have client records that include: names and address, the type and dates of service provided, the number of units of service provided, and documentation that service was provided.

*The applicant certifies to the best of its knowledge and belief, that it is not an **"Ineligible Organization"** as defined in section VIII of this application. The applicant further certifies to the best of its knowledge and belief, that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and , (4) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default.*

Authorized Signature and Title _____ Date _____

Name of Agency (Service Provider) _____

- **Electronic signature is considered valid only when document is submitted by e-mail from the signer's e-mail address.**
- **If mailing or faxing application, signature must be handwritten.**

SUBMIT YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:

Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186
262-446-6707 (Fax)

E-mail: contractinquiries@communitycareinc.org

For questions please call our Provider Hotline at 866-937-2783, option 2