Transportation Information Request Form

For applicants applying for Category of Service 0602- Ambulette: Under current Department of Health (DOH) policy, new ambulette providers *will be denied enrollment* for service to New York City, Nassau and Suffolk County. DOH has determined that these locations have an adequate number of existing ambulette providers [New York State Medicaid Program Transportation Manual Policy Guidelines, page 22].

Form Instructions

1. This form may be downloaded and completed electronically.
2. If additional room is needed to provide a complete response to any question, include the information on a separate page and attach it to this form. Be sure to indicate the corresponding question number on your attachment.
3. If this application is for a change of ownership or impending change of ownership, you must submit a separate signed statement stating that 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.
4. **Answer every question. Any questions left blank, including failure to provide the required attachments, may result in the denial of the application pursuant to NYCRR Title 18 § 504.5 (a)(1).**

Ownership and Disclosures

1. If the Applicant/Business Name indicated on the NY Medicaid Provider Enrollment Form (EMEDNY-436701) is a Corporation or Limited Liability Company, you must provide the following:

Corporation Information: List all shareholder information.

Shareholder Name	Date of Birth	Social Security Number	Percentage of Ownership Shares

Attach a copy of the Certificate of Incorporation and stock certificate for each shareholder.

If this question does not apply, indicate so by checking this box ☐

Limited Liability Company Information: List all individual member information.

Member Name	Date of Birth	Social Security Number	Percentage of Membership Interest

Attach a copy of the Articles of Organization and membership certificate for each member.

If this question does not apply, indicate so by checking this box ☐

2. If any owner listed in the Disclosure of Ownership and Control Section of the NY Medicaid Provider Enrollment Form (EMEDNY-436701) or in Question 1 of this form has any other known names list the owner and their alias.

Owner Name	Alias

If this question does not apply, indicate so by checking this box ☐

3. List the names of all other current or former companies or corporations owned or operated by any individuals listed in the Disclosure of Ownership and Control Section of the NY Medicaid Provider Enrollment Form (EMEDNY-436701).

Company Name	FEIN or Provider Number	Owner(s)–name all

If this question does not apply, indicate so by checking this box ☐

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 the Disclosure of Ownership and Control Section of the NY Medicaid Provider Enrollment Form (EMEDNY-436701).

Company Name	FEIN or Provider Number	Owner(s) and relationship to individual named in Section 1

If this question does not apply, indicate so by checking this box ☐

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

Last Name, First Name	License Number (State)	Profession	NPI or Provider Number

If this question does not apply, indicate so by checking this box ☐

6. Provide an employment history (5 years) for all individuals listed in Sections 1 and 5 of the NY Medicaid Provider Enrollment Form (EMEDNY-436701) and in Question 1 of this form. **Copy this page and attach additional sheets if necessary.**

Owner/Manager's Name	
Current Position	
Name of Past Employer:	
Address and Phone Number of Past Employer	
Employment Dates (Start date to End date)	
Nature of Duties (Must be specific)	

Owner/Manager's Name	
Current Position	
Name of Past Employer:	
Address and Phone Number of Past Employer	
Employment Dates (Start date to End date)	
Nature of Duties (Must be specific)	

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Current Position	
Name of Past Employer:	
Address and Phone Number of Past Employer	
Employment Dates (Start date to End date)	
Nature of Duties (Must be specific)	

Business Operations

7. Is your transportation business currently open and operating? Yes ☐ No ☐
   Please note all business operations must be in accordance with Medicaid Transportation Policy Guidelines prior to enrollment.

8. Complete the table below to show the address information for the various aspects of your business. If you have other locations than those listed, identify the other location and identify the business purpose.

Business Locations	Address and Phone Number	Rent* or Own	Landlord's Name and Phone Number
Main Office/Service			
Vehicle Storage			
Record Storage			
Billing Processed			
Other:			

***Attach a signed copy of the current lease and a copy (front and back) of the most recent canceled rent check for all rental listed above.**

9. Are there any other businesses located at your service address? Yes ☐ No ☐

   If yes, list the businesses:

Business Name	Business Type

If your business is in a large building complex and the other building occupants are unknown, please check this box ☐ **Attach a photo of your business location.**

10. Which geographic area(s) will you serve?

Attach TLC certificate for all areas which require one. See checklist on page 10.

11. Indicate the hours and type of transportation services provided each day of the week:

	Hours of Operation	Service Type (Taxi/Livery/Ambulette)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

12. List all individuals or entities that will be involved in Medicaid billing. Include the name of any billing service used.

Name (Last, First)	Position	Social Security #	Date of Birth

13. List all office personnel.

Name (Last, First)	Position	Social Security #	Date of birth

14. List all drivers.

Name (Last, First)	Driver's License #	State	Social Security #	Date of birth

Attach a copy of the driver's license, and TLC license if applicable, for each driver listed. **All drivers must be licensed in accordance with Medicaid Transportation Policy Guidelines. A Class D license is not acceptable for providing Medicaid Transportation.*

15. List the vehicle information for each vehicle (owned or leased) which is or will be operated by your company for providing Medicaid transportation services.

Registrant Name	Plate #	Make/Model	Year	Vehicle Identification Number (VIN)

Attach a copy of the registration for each vehicle listed. **All vehicles must be registered in accordance with Medicaid Transportation Policy Guidelines. Passenger registration is not acceptable for providing Medicaid Transportation.*

16. Does your company use subcontractors? Yes ☐ No ☐

    If yes, complete the following:

Subcontractor Name	Plate #	Make/ Model	Year	Vehicle Identification Number (VIN)

Subcontracting must be in accordance with Medicaid Transportation Policy Guidelines.

17. Have any of the subcontractors ever been affiliated with another transportation company?
    Yes ☐ No ☐

    If yes, please provide the following:

Individual's Name	Affiliated Business Name	Prior Role	NPI or Provider Number

Financial Disclosures

18. Provide the information below for all accounts to be used by the business.

Bank Name	Address	Account Number	Account Holder's Name(s)

19. Provide the information below for all personnel authorized to sign checks against the accounts listed above:

Person(s) Authorized to Sign Checks	Social Security Number

This page must be printed and submitted with original signatures.

Certification

I certify, to the best of my knowledge and belief, that all information contained in and attached to this application for enrollment in the Medicaid program is complete and accurate. I understand that failure to provide complete and accurate information may result in denial of enrollment.

By signing below, I acknowledge that I have read the New York State Medicaid Transportation Manual Policy Guidelines (eMedNY.org). and I agree to comply with the Policy Guidelines. I understand that failure to comply with Policy Guidelines will result in denial of enrollment.

Owner's Name (print): _____

Owner's Signature: _____ Date: _____

(Signature stamps are not permitted)

Attach a copy of photo identification including signature.

Application Prepared by (print): _____ Date: _____

Preparer's Affiliation to Applicant _____

Telephone Number: _____

Application Completeness Checklist

If applicable, please make sure all the following documents are attached. Failure to do so may result in denial of the application pursuant to New York Codes, Rules, and Regulations Title 18 § 504.5 (a)(1).

For all applicants:

- A copy of the vehicle registration for each vehicle listed in response to question 15.
- A copy of the driver's license for all drivers listed in response to question 14.

For those applying for Category of Service 0602 Ambulette:

- Department of Transportation certificate of inspection for each ambulette vehicle
- Department of Motor Vehicles Article 19-A Annual Affidavit of Compliance
- Department of Transportation Letter of Permit
- A copy of the surety bond if applicable (see Transportation Manual Policy Guidelines)

For those applying for Category of Service 0603 Taxi in Nassau County:

- Proof of Taxi & Limousine Commission (TLC) certification for each vehicle listed in response to question 14.

For those applying for Category of Service 0603 Taxi in Westchester County:

- A copy of the Westchester County TLC For-Hire Base Station Permit

For those applying for Category of Service 0603 Taxi in Suffolk County:

- A copy of the TLC certificate for the transportation company

For those applying for Category of Service 0605 Livery in NYC:

- A copy of the New York City TLC license for each driver
- A copy of the New York City TLC For-Hire Vehicle Base License