Transportation Application

Checklist

The items below must be completed *prior to submission* and included with this application to be considered. If all items are not received at time of application, this application will not be accepted.

☐ Transportation Provider Application ***– all transportation providers must have a minimum of 2 drivers and 2 vehicles to be considered.***

☐ Attestation Form (**Word** or **PDF** format)

☐ **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. as a certificate holder (1801 Dolphin Drive, Waukesha, WI 53186)

☐ Electronic Funds Transfer Form (**Word** or **PDF** format))

☐ Voided Check *OR* Bank Letter to accompany the Electronics Funds Transfer form

☐ DHS Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation https://www.dhs.wisconsin.gov/library/collection/f-00180c

COMMUNITY CARE, INC.
TRANSPORTATION APPLICATION

I. PROVIDER CONTACT INFORMATION – *Please Type or Print*

Legal Entity Name: _____

Business Mailing Address: (cannot be a P.O. Box)

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Mailing Address: **Same as Mailing Address Above** ☐

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Tax Id: _____ NPI #: _____

Medicaid #: _____ Medicare #: _____

EVV #: _____

Contact Name: _____ Title: _____

Contact E-Mail: _____ Phone: _____

Contract Signer: _____

Signer's Title: _____

Website: _____

Days of Operation: _____

Hours of Operation: _____

II. GENERAL INFORMATION

OWNERSHIP INFORMATION

☐ The organization is minority-owned.
☐ The organization is woman-owned.
☐ The organization is disabled veteran-owned.
☐ The organization is a small business.

Do you currently have or have you previously had a contract with CCI?
☐ Yes ☐ No Please explain: _____

Do you have an affiliation with another Legal Entity currently contracted with CCI?
☐ Yes ☐ No What is the affiliation: _____

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

SERVICE AREA(S):

All 72 Wisconsin Counties	☐										
Adams	☐	Dane	☐	Iowa	☐	Marathon	☐	Polk	☐	Taylor	☐
Ashland	☐	Dodge	☐	Iron	☐	Marinette	☐	Portage	☐	Trempealeau	☐
Barron	☐	Door	☐	Jackson	☐	Marquette	☐	Price	☐	Vernon	☐
Bayfield	☐	Douglas	☐	Jefferson	☐	Menominee	☐	Racine	☐	Vilas	☐
Brown	☐	Dunn	☐	Juneau	☐	Milwaukee	☐	Richland	☐	Walworth	☐
Buffalo	☐	Eau Claire	☐	Kenosha	☐	Monroe	☐	Rock	☐	Washburn	☐
Burnett	☐	Florence	☐	Kewaunee	☐	Oconto	☐	Rusk	☐	Washington	☐
Calumet	☐	Fond du Lac	☐	LaCrosse	☐	Oneida	☐	Sauk	☐	Waukesha	☐
Chippewa	☐	Forest	☐	Lafayette	☐	Outagamie	☐	Sawyer	☐	Waupaca	☐
Clark	☐	Grant	☐	Langlade	☐	Ozaukee	☐	Shawano	☐	Waushara	☐
Columbia	☐	Green	☐	Lincoln	☐	Pepin	☐	Sheboygan	☐	Winnebago	☐
Crawford	☐	Green Lake	☐	Manitowoc	☐	Pierce	☐	St. Croix	☐	Wood	☐

Hours of Operation:
24 Hour Facility Yes ☐ No ☐
If no, list Hours:
Weekdays (Mon–Fri):
Weekends (Sat–Sun):
Please list the holidays your organization will transport:

III. SERVICES OFFERED

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

SERVICES		CHECK SERVICE YOU PROVIDE
Transportation (specialized transportation) – community transportation is the provision of transportation services or items that enable a member to gain access to waiver and other community services, activities and resources, as specified in the member's care plan.		☐
Transportation (specialized transportation) - other transportation consists of transportation to receive non-emergency, Medicaid–covered medical services.		☐

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.

☐ Specialized Medical Vehicle Certification

☐ Other: _____

Target Group(s): *Please select the population(s) you serve*

Physically Disabled (PD)	☐	Frail Elderly (FE)	☐
Intellectually/Developmentally Disabled (IDD)	☐	All (PD, IDD, FE)	☐

Do you wish to be published in Community Care's public provider directory? ☐ Yes ☐ No

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

List fluent languages spoken by staff (other than English):

_____

IV. PROVIDER ACCESSIBILITY

TDD/TTY Number	_____	
Handicapped accessible	☐ Yes	☐ No
Sign Language	☐ Yes	☐ No
Bariatric	☐ Yes	☐ No

V. CULTURAL COMPETENCIES

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

Does your agency perform Cultural Competency Training? ☐ Yes ☐ No

Has your agency implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS)? https://thinkculturalhealth.hhs.gov/clas ☐ Yes ☐ No

VI. 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).

VII. LENGTH OF TIME IN BUSINESS

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

_____ Years _____ Months

VIII. AGENCY OFFICERS/RESPONSIBLE PARTY

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

Those listed in this section have authority to speak with and receive information from Community Care, Inc.

Position	Name	Telephone & Email
Chief Operations Officer:		
Executive Director/President:		
Chief Financial Officer:		
Chief Information Technology Officer:		
Human Resources Director:		
Other:		

IX. GOVERNANCE

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

If yes, please answer the below:

How many members are on the Board? _____

Does at least 51% of the Board of Directors include minorities, women, disabled Veterans and/or small business owners? ☐ Yes ☐ No

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: _____

X. 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.**

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.**

Returned your application with ALL REQUIRED documentation to:

Email (preferred method):
ContractInquiries@communitycareinc.org

Mail to:
Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186

Fax to:
(262) 446-6707

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