SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Virginia

REQUEST FOR QUALIFICATIONS (RFQ) – PROVIDER'S CREDENTIALS

CLASSIFICATION

1 Application Type		New		Anniversary		Renewal		Revision
2 Mode of Transport:		Ambulatory		Wheelchair		Stretcher		Bariatric Str

OWNERSHIP

3 (Check One)		Individual		Partnership		Corporation		LLC
		State Gov.		County Gov.		Hosp. Auth.		Non-Profit

4a Name of Owner(s):			4b Email Address:
5a Owner Street Address			5b Business Phone:
6a City:	6b State:	6c Zip Code + 4:	6d Fax Number:
7 NPI Number:		8 Medicaid ID Number:	

MANAGEMENT (If different from Owner)

9a Operations Manager:			9b Email Address:
10a Street Address:			10b Business Phone:
11a City:	11b State:	11c Zip Code:	11d Fax:

BASIC QUALIFICATIONS

12a Has the owner or any party to this application had any certification or license revoked or had any other disciplinary actions levied from any state or federal agency? ***If yes, attach documentation explaining the circumstances.**	12b Yes/No?
13a Has the owner or any party to this application ever been convicted of a felony by this or any other state or federal court? ***If yes, attach documentation explaining the circumstances.**	13b Yes/No?
14a Is the owner, or any party to this application currently in any pending matter referred to in the preceding two items? ***If yes, attach documentation explaining the circumstances.**	14b Yes/No?

OPERATIONAL INFORMATION

15a Name of Service:			15b Number of Vehicles:
16 Doing Business As:			
17a Business Hours:	17b After Hours Service(Circle One) Yes No	17c Long Distance Trips (Circle One) Yes No	
18a Is the owner or any party to this application currently in a contractual or similar agreement with another agency for the provision of transportation of patients, members and/or clients? ***If yes, attach copy of contract/agreement.**			18b Yes/No?
19a Contractor/Contractee: (If additional space is needed, attach separate page)			

BUSINESS LOCATION (If Different from Owner's Address)

20a Business Location - Street Address:		20b County:
21a City:	21b State:	21c Zip Code:
22a Local Manager's Name:		22b Email Address:

23a Business Phone:	23b Emergency Phone:	23c Fax:

ADDITIONAL SATELLITE LOCATION(S) MUST BE RECORDED ON AN ADDITIONAL SHEET OF PAPER

PAYMENT INFORMATION

24a Federal Tax Identification Number:	24b Email Address:

24c Payment Mailing Address: Street City State Zip

MANIFEST/TRIP REQUEST RECEIPT METHOD

25 Manifest Email Address:

26 Manifest Fax Number:

26a Are you currently using any mobile or routing software other than that offered by the current broker? If so, please indicate the name of the software and/or the vendor.

CERTIFICATION

The undersigned certifies that the information contained in this application and all attached documentation is true and correct to the best of my knowledge and belief and that I will comply with Southeastrans, Inc. Rules and Policies, as amended, governing Independent Provider's contract. Provider shall operate as an independent Provider in providing services under this Contract, and not as an agent, representative or employee of Southeastrans.

27 Owner's Name:

28a Owner's Signature:	28b Date:

29 Owner #2 Name (if applicable):

30a Owner #2 Signature:	30b Date:

SERVICE AREA (Counties you will service):

ADDITIONAL INFORMATION:

Are you currently providing or have you ever provided transportation for Medicaid members? Yes or No (circle one)

How many trips per day can you transport with your current fleet of vehicles (by level of service)?

Are you willing to travel outside your service area if needed? If so, please define those areas.