SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Georgia

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 LP Number/IHCP Number:			

NOTE: In fields above, you MUST enter zip and 4-digit code. A physical address is required. Not a P.O. Box.

BASIC QUALIFICATIONS

8a 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.**	8b Yes ◯	No? ◯
9a 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.**	9b Yes ◯	No? ◯
10a 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.**	10b Yes ◯	No? ◯

OPERATIONAL INFORMATION

11a Operations Manager:		11b Email Address:	
12a Name of Service:			12b Number of Vehicles:
13 Doing Business As:			
14a Days of Operation:		14b Hours of Operation:	
15a 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.**		15b Yes ◯	No? ◯

BUSINESS LOCATION (If Different from Owner's Address)

16a Business Location - Street Address:		16b County:
17a City:	17b State:	17c Zip Code:
18a Local Manager's Name:		18b Email Address:

19a Business Phone:	19b Emergency Phone:	19c Fax:

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

MANIFEST/TRIP REQUEST RECEIPT METHOD

20 Manifest Fax Number:

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.	
21 Owner's Name:	
22a Owner's Signature:	22b Date:
23 Owner #2 Name (if applicable):	
24a Owner #2 Signature:	24b Date:

SERVICE AREA (Counties you will service. Counties of trip origination.):

ADDITIONAL INFORMATION:

What experience do you have transporting Medicaid members?

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

Could you provide professional service references from agencies your have worked with or are currently working with?

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

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GEORGIA NET PROVIDER EMPLOYEE LIST

NET Provider Name:			**Date:**
Phone #:	**Fax #:**	**E-Mail:**	

Driver's Name	Date of Birth	Social Security Number	Driver's License #	Employee Type
				☐ Driver ☐ Attendant ☐ Delete
				☐ Driver ☐ Attendant ☐ Delete
				☐ Driver ☐ Attendant ☐ Delete
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				☐ Driver ☐ Attendant ☐ Delete

Southeastrans must approve all drivers and attendants (if applicable) before they can begin transporting/attending Medicaid Members. If you need to delete a previously authorized employee because they are no longer employed by your company, record their name and information on this list, check "Delete", and attach a separation notice.

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DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

GEORGIA NET PROVIDER VEHICLE LIST

NET Provider Name:						Date:
Phone #:		Fax #:			E-Mail:	
Make	Model	Vehicle ID # (VIN)	Year	Tag Number	Vehicle Type	Average Daily Capacity (Enter the usual number of daily one-way trips by mobility/vehicle)
					☐Amb ☐W/C	☐ Ambulatory ☐ W/C
					☐Amb ☐W/C	☐ Ambulatory ☐ W/C
					☐Amb ☐W/C	☐ Ambulatory ☐ W/C
					☐Amb ☐W/C	☐ Ambulatory ☐ W/C
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					☐Amb ☐W/C	☐ Ambualtory ☐ W/C

All vehicles must be inspected and authorized by Southeastrans before transporting passengers. Vehicle information must be correct and current at all times. All providers must immediately contact Southeastrans if a vehicle on this list is removed from your fleet and/or a new vehicle needs to be added.

SUBMIT

Reset