

# Human Service Transportation (HST) Provider Application

This application is for any transportation provider who seeks to subcontract with HST Brokers to provide trips for consumers/clients of one or more state programs (MassHealth, Dept. of Mental Retardation, DPH – Early Intervention, etc.)

Rev. 2/08 *Print or type (turn off insert key) entries and sign in Blue ink.*

## **SECTION I. ORGANIZATIONAL INFORMATION**

### 1.1 Provider Information

DATE: \_\_\_\_\_

Legal name: \_\_\_\_\_ If applicable, MassHealth provider # \_\_\_\_\_

List any "Doing Business As" (DBA) names: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Ambulance companies only – National provider identifier (NPI): \_\_\_\_\_ Taxonomy: \_\_\_\_\_

Please identify the types of transportation you provide (Check all that apply):

- Wheelchair van       Ambulance       Ambulatory (taxi, livery, van, sedan)

If you have provided transportation for one or more HST Brokers within the last 5 years, please list which ones:

\_\_\_\_\_

If new, please describe the area(s) of the state you wish to serve: \_\_\_\_\_

### 1.2 Organizational Information

Please identify your legal-entity type (documentation will be required):

- A.  Corporation (indicate type of corporation below)  
 Profit (includes limited liability and professional corporations)       Nonprofit  
State where incorporated: \_\_\_\_\_ Date of incorporation: \_\_\_\_\_

- B.  Partnership (indicate type of partnership below)  
 Limited partnership, profit       General partnership, profit  
 Limited partnership, nonprofit       General partnership, non profit  
 Limited liability partnership, profit       Other (specify): \_\_\_\_\_  
 Limited liability partnership, nonprofit  
State where partnership was formed: \_\_\_\_\_ Date partnership was formed: \_\_\_\_\_

- C.  Trust (indicate type of trust below)  
 Profit       Nonprofit  
State where trust was established: \_\_\_\_\_ Date trust was established: \_\_\_\_\_

- D.  Government (indicate type of governmental entity below)  
 Federal       County       State       Municipal

- E.  Other entity (specify): \_\_\_\_\_

### 1.3 SOMWBA Status (If applicable, copy of SOMWBA certificate must be attached: # and Expiration Date \_\_\_\_\_)

- Is Company SOMWBA certified?       Yes       No  
If yes, check applicable category:       MBE       WBE       M/WBE       M/WBE Non-Profit

**SECTION 1. ORGANIZATIONAL INFORMATION (cont.)**

**1.4 History of Ownership**

Has this organization had other owners in the past 10 years?

- Yes. Provide the information requested below. Space is provided for two previous owners.
- No.

Previous owner's name:	Previous Tax ID #:
Previous MassHealth provider name, if applicable:	MassHealth provider #, if applicable
Dates of ownership (from/through):	

Previous owner's name:	Previous Tax ID #:
Previous MassHealth provider name, if applicable:	MassHealth provider #, if applicable
Dates of ownership (from/through):	

(Attach additional pages, if necessary)

**1.5 Related Ownership**

Have any Principals of this Company been owners or operators of another transportation company (presently in business or dissolved)? If so, please provide details (name of company, date dissolved, if applicable, state in which company operates/operated):

**SECTION 2. ADDRESS INFORMATION**

**2.1 Legal Entity Address**

Name of Business: \_\_\_\_\_  
Street Address or P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Contact person: \_\_\_\_\_ Office phone #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Office fax #: \_\_\_\_\_

Please choose the method by which this office prefers to be contacted:

- E-mail
- Phone
- Fax
- Mail

**2.2 Physical Address (Service Site)**

Complete this section for each service site. A service site is a place where you dispatch transportation vehicles.

(Attach additional pages, if necessary)

Location #1 – Is this location:

- A garage or central dispatch office?
- A branch site?
- An office?

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Contact person: \_\_\_\_\_ Office phone #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Office fax #: \_\_\_\_\_

Please choose the method by which this office prefers to be contacted:

- E-mail
- Phone
- Fax
- Mail

**SECTION 2. ADDRESS INFORMATION (cont).**

Location #1 continued:

Does this site have TTY/TDD capability?  Yes  No If yes, phone #: \_\_\_\_\_  
Does this site provide 24-hour coverage?  Yes  No

**2.3 Languages**

Please identify languages other than English that are spoken by your dispatchers and drivers:

Language: \_\_\_\_\_  
Language: \_\_\_\_\_

**2.4 Payment Address**

Name of business: \_\_\_\_\_  
Street Address or P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Contact person: \_\_\_\_\_ Office phone #: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Office fax #: \_\_\_\_\_

Please choose the method by which this office prefers to be contacted:  
 E-mail  Phone  Fax  Mail

**SECTION 3. PROVIDER INFORMATION**

**3.1 Licensure/Certification Information**

Are you licensed or certified by any state or local regulatory agency relative to provision of transportation?  
 Yes (Complete information below)  No

Lic/Cert. type: \_\_\_\_\_ Lic/Cert. no.: \_\_\_\_\_ State: \_\_\_\_\_ Effective from: \_\_\_\_\_ to: \_\_\_\_\_  
Lic/Cert. type: \_\_\_\_\_ Lic/Cert. no.: \_\_\_\_\_ State: \_\_\_\_\_ Effective from: \_\_\_\_\_ to: \_\_\_\_\_  
Lic/Cert. type: \_\_\_\_\_ Lic/Cert. no.: \_\_\_\_\_ State: \_\_\_\_\_ Effective from: \_\_\_\_\_ to: \_\_\_\_\_

**3.2 Former MassHealth Provider Numbers, if applicable**

Please list former (if any) MassHealth provider numbers:

Provider #: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Provider #: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Provider #: \_\_\_\_\_ Provider Name: \_\_\_\_\_

**3.3. Other Contracting Agreements**

Do you contract with any of the following entities?

- Nursing facilities
- Day habilitation programs
- Adult day health program
- School systems/Head Start
- Other (e.g., hospitals or other state agency programs), specify: \_\_\_\_\_

Complete the list of Transportation Contracts (see attachment)

## SECTION 4. QUESTIONS

If you answer yes to any of the questions below, please explain in 4.4

### 4.1 Questions about Licensure and Driving Privileges

1. Have any disciplinary actions been threatened or initiated, or are any pending against the company or any of its drivers, by a state licensure board or agency?  Yes  No
2. Has the license of any driver in your organization, in any state, ever been denied, limited, suspended, revoked, diminished, not renewed, or relinquished (voluntarily or involuntarily), within the last 5 years or are any proceedings pending that may result in such action?  Yes  No
3. Have any formal complaints been filed against the company with any state licensing board?  Yes  No

### 4.2 Questions about Liability Insurance and Claims

4. Has the company's vehicle insurance coverage ever been terminated by action of an insurance company?  Yes  No
5. Has the company's personal liability insurance coverage ever been terminated by action an insurance company?  Yes  No
6. Have there been any legal proceedings or claims against the company, alleging negligence or failure to observe transportation or motor vehicle rules that are open, pending, or closed within the past 10 years?  Yes  No

### 4.3 Miscellaneous Questions

7. Have any of the company's drivers ever been convicted of a speeding or traffic violation or other motor vehicle Offense?  Yes  No
8. Have any driver or monitor's annual Criminal Offender Record Information (CORI) check produced results that could disqualify their hiring under 101 CMR 15.00?  Yes  No

### 4.4 Explanation for any yes answers (attach additional sheets)

## **SECTION 5. REQUIRED ATTACHMENTS**

Please attach a copy of the following documents to your signed application

- The applicable organization documentation – see below for guidance
- Completed and signed W-9 form, if applicable
- SOMWBA Certification, if applicable
- Business Certification (form attached)
- List of transportation contracts (form attached)
- Certificate of vehicular insurability (form available)
- Acceptance of performance standards (form available)
- Signature verification (form available)

For all corporations

- Articles of Organization with all amendments

For all limited partnerships

- Limited partnership agreement with any amendments
- Certificate of Legal Existence for Massachusetts limited partnerships or Certificate of Foreign Registration (for limited partnership established in a state other than Massachusetts)

For all general partnerships

- Partnership agreement

For all trusts

- A copy of the declaration of trust

## **SECTION 6 ATTESTATIONS AND RELEASE OF INFORMATION**

This form will become part of (and is incorporated by reference into) any subsequent HST contract between this provider and any HST Broker. This provider grants the HST Broker or HST Office permission and consent to obtain and verify information contained in this application for participation in HST and its attachments, and grants consent for any person, organization, or other entity to release to the HST Broker, its agents, or the HST Office all information that may be reasonably relevant to an evaluation of the provider's professional competence or its ability to provide services in a professional manner. The provider understands that participation in HST is dependent upon review of the material contained in and submitted with this form and successful qualification based in this information.

The provider certifies that the information in its application and its attachments is true, accurate, and complete. The provider further understands that any information entered in its application and attachments that subsequently is found to be false could result in the termination of any HST contract.

The person signing below warrants that he or she is an authorized representative of the provider and has the authority to sign on behalf of the provider. Accepted and agreed to:

Legal Name of Provider: \_\_\_\_\_

Signature of Provider or Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Person signing: \_\_\_\_\_ Title of Person Signing: \_\_\_\_\_

# Human Service Transportation (HST) Provider Business Certification

Provider Name: \_\_\_\_\_

Legal Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By executing this Certification Form, the Transportation Provider makes, under the pains and penalties of perjury, all certifications required below and affirms it has provided all required documentation, or shall provide any required documentation upon request. A signed, valid Certification Form is a pre-requisite to becoming qualified as an HST Transportation Provider.

*An authorized signatory must initial each line as acceptance or certification of that term.*

\_\_\_ **1. AFFIRMATIVE ACTION, NON-DISCRIMINATION IN HIRING AND EMPLOYMENT:** The Provider is and will remain in compliance with all federal and state laws, rules and regulations promoting fair employment practices or prohibiting employment discrimination and unfair labor practices. If a contract is awarded, the Provider commits to purchasing supplies and services from certified minority or women-owned businesses, small businesses or businesses owned by socially or economically disadvantaged persons or persons with disabilities.

\_\_\_ **2. NOT DEBARRED:** The Provider certifies that it and any of its proposed subcontractors are not currently debarred or suspended by the federal or state government under any law or regulation.

\_\_\_ **3. TAX COMPLIANCE:** The Provider certifies Tax Compliance with [Federal tax laws](#); State tax laws including [G.L. c. 62C](#), [G.L. c. 62C, s. 49A](#) (the Provider has complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support and is in good standing with respect to all returns due and taxes payable to the commissioner of revenue); reporting of employees and contractors under [G.L. c. 62E](#), withholding and remitting [child support](#) including [G.L. c. 119A, s. 12](#).

\_\_\_ **4. NO RECENT BANKRUPTCY/RISK:** The Provider certifies it has not been in bankruptcy and/or receivership within the last three calendar years, and the Provider certifies that it will immediately notify the Broker(s) in writing if there is any risk to the solvency of the Provider that may impact the Provider's ability to timely fulfill the terms of any Transportation Contract with an HST Broker.

\_\_\_ **5. DISCLOSURE OF JUDGEMENTS/CONVICTIONS ETC.:** The Provider shall affirmatively disclose the details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Provider or any of its officers, directors, employees, agents, or subcontractors of which the Provider has knowledge, or learns of during the term of any Transportation Contract with an HST Broker. Providers must affirmatively disclose any [potential structural change](#) in its organization at least 45 days prior to the change.

\_\_\_ **6. FILING OF REQUIRED CERTIFICATES AND REPORTS:** The Provider certifies compliance with filing requirements for the [Secretary of the Commonwealth](#) and [Office of the Attorney General](#) or other Departments as related to its conduct of business in the Commonwealth.

**\_\_\_7. EMPLOYER REQUIREMENTS:** If an employer, the Provider certifies compliance with applicable state and federal employment laws or regulations, including but not limited to [\*minimum wages and prevailing wage programs and payments\*](#); [\*unemployment insurance\*](#) and contributions; [\*workers' compensation and insurance\*](#), [\*child labor laws\*](#), [\*AGO fair labor practices\*](#); [\*G.L. c. 149\*](#) (Labor and Industries); [\*G.L. c. 150A \(Labor Relations\)\*](#); [\*G.L. c. 151\*](#) and [\*455 CMR 2.00 \(Minimum Fair Wages\)\*](#); [\*G.L. c. 151A\*](#) (Employment and Training); [\*G. L. c. 151B\*](#) (Unlawful Discrimination); [\*G.L. c. 151E\*](#) (Business Discrimination); [\*G.L. c. 152\*](#) (Workers' Compensation); [\*G.L. c.153 \(Liability for Injuries\)\*](#); [\*29 USC c. 8\*](#) (Federal Fair Labor Standards); [\*29 USC c. 28\*](#) (Federal Family and Medical Leave Act); [\*AGO Consumers and Civil Rights\*](#).

**\_\_\_8. ANTI-LOBBYING REQUIREMENTS:** The Provider certifies compliance with federal anti-lobbying requirements including [\*31 USC 1352\*](#); [\*other federal requirements when receiving federal funds\*](#); [\*Executive Order 11246\*](#); [\*Air Pollution Act\*](#); [\*Federal Water Pollution Control Act\*](#).

**\_\_\_9. DRUG FREE WORKPLACE:** The Provider commits to a drug-free workplace, in accordance with the Drug-Free Workplace Act of 1988 (41 USC 702)

This certification will become part of (and is incorporated by reference into) any subsequent HST contract between this Provider and any HST Broker.

The person signing below warrants that he or she is an authorized representative of the Provider and has the authority to sign on behalf of the Provider. Accepted and agreed to:

Legal name of provider: \_\_\_\_\_

Signature of provider or authorized representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of person signing: \_\_\_\_\_

Title of person signing: \_\_\_\_\_

## TRANSPORTATION CONTRACTS LIST

Please complete for all current, expired and or terminated transportation contracts held by the Provider within the last three (3) years, starting with the most recent. Attach additional pages, as needed.

**Provider Legal Name:** \_\_\_\_\_

**Legal Address:** \_\_\_\_\_  
\_\_\_\_\_

Customer Name: \_\_\_\_\_ Contact: Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # : \_\_\_\_\_

Fax/Internet address: \_\_\_\_\_

Current  Expired  Terminated Date(s) of services provided: \_\_\_\_\_

Description of services: \_\_\_\_\_  
\_\_\_\_\_

Customer Name: \_\_\_\_\_ Contact: Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # : \_\_\_\_\_

Fax/Internet address: \_\_\_\_\_

Current  Expired  Terminated Date(s) of services provided: \_\_\_\_\_

Description of services: \_\_\_\_\_  
\_\_\_\_\_

Customer Name: \_\_\_\_\_ Contact: Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # : \_\_\_\_\_

Fax/Internet address: \_\_\_\_\_

Current  Expired  Terminated Date(s) of services provided: \_\_\_\_\_

Description of services: \_\_\_\_\_  
\_\_\_\_\_

Customer Name: \_\_\_\_\_ Contact: Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # : \_\_\_\_\_

Fax/Internet address: \_\_\_\_\_

Current  Expired  Terminated Date(s) of services provided: \_\_\_\_\_

Description of services: \_\_\_\_\_  
\_\_\_\_\_

*References will be contacted to confirm the Provider's abilities and qualifications. Provider qualification may be affected if a reference is not obtainable after reasonable attempts and/or if the transportation contract list is incomplete.*