DEPARTMENT OF HEALTH
AND HOSPITALS
*Medicaid*

MOLINA
Medicaid Solutions

# PROVIDER TYPE SPECIFIC CHECKLIST PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

## (Louisiana Medicaid Program)

# Non-Emergency Medical Transportation

(PT 42)
Revised 05/14

# STOP!!!

**If an owner or a co-owner has been convicted of any of the criminal offenses listed below, you must contact NEMT Program Desk at 225 342-9404 before going any further:**

- **Medicaid, Medicare, any other healthcare program fraud;**
- **Neglect or abuse of a patient;**
- **Unlawful manufacture, distribution, prescription or dispensing of a controlled substance;**
- **Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;**
- **Sexual acts;**
- **Interference or obstruction of an investigation into any of the above criminal offenses.**

Louisiana Medicaid

Molina Medicaid Solutions
PO Box 80159
Baton Rouge, LA 70898-0159

Provider Enrollment Unit
(225) 216-6370

MOLINA Medicaid Solutions

Dear Prospective NEMT Provider:

As per your request, attached you will find an enrollment application with all of the forms needed to enroll in the Medicaid, Non Emergency, Non-Ambulance, Medical Transportation (NEMT) Program. We thank you for your interest in becoming a Medicaid NEMT provider.

All providers must be certified to participate in the Medicaid program. This requires that you correctly complete all forms and successfully pass an inspection in accordance with State Regulations. Please note that some forms must be notarized.

Before doing anything else, you must contact the Health Standards NEMT Program Desk at 225-342-9404 to verify that your business name is not already in use by another provider or prospective provider.

Prior to completing and submitting the enclosed forms, you must do the following things:

- Register your business and its name with the Louisiana Secretary of State's office.
- Obtain an IRS Taxpayer Identification Number in your business name.
- Open a checking account in the name of your proposed transportation business entity.
- Obtain a suitable vehicle (no pick up trucks or two door sports cars).
- Complete a MT-10 Form (enclosed) and submit it to the Louisiana Public Service Commission.
- Register the vehicle with the Louisiana Department of Public Safety, Office of Motor Vehicles. You must register the vehicle in your business name and you must purchase a "For Hire" license plate.
- Have each prospective driver obtain a Louisiana Chauffeurs' License (Class D or higher) from the Office of Motor Vehicles. While the driver is obtaining his or her chauffeurs' license, have them obtain a copy of their online driver record.
- Obtain the required Healthcare Provider Criminal Background Check from the Louisiana State Police, Bureau of Criminal Identification or one of their authorized vendors for any and all drivers you intend to hire. The Department will need to review the healthcare provider's criminal background check prior to approving your application. This office does **not** accept criminal background checks from municipal police departments, sheriff's departments, or parish clerks or court.
- Have each prospective driver successfully complete the National Safety Council Defensive driving course, DDC-6, or an equivalent approved by the Department.
  **Please note that we do not accept on-line defensive driving courses.**
- Purchase both commercial automobile liability and commercial general liability insurance that meets the Department's requirements. Have the agent send the
  Department both the Certificate of Insurance and a letter stating that your insurance has been paid in advance for 90 days. The Department does not accept insurance binders or Louisiana Insurance Identification Cards.
- Publish your "Notice of Intent to do Business" in the appropriate local newspapers. Submit a copy of the notice from the paper or "An Affidavit of Publication" to the Department.
- If you are operating your business in Jefferson, and Orleans parishes and the City of Shreveport you must apply for and, be granted the appropriate non-emergency medical transportation permit.

Once you have completed all of the above, complete the enclosed forms, notarize those forms that need notarization, and add any required documents outlined in the check list. Mail all of the forms from **both the**

**Medicaid Business Entity Provider Enrollment packet,** and the type specific **PT 42, Non Emergency Medical Transportation Provider Enrollment packet** to the following address:

DHH Health Standards
NEMT Program Desk
Post Office Box 3767
Baton Rouge, Louisiana, 70821-3767

Once the NEMT Program Desk receives your packet it takes at least two weeks to process your packet. If anything is missing or is incorrect, the application will be returned to you. **Every time a packet is returned to you it delays your enrollment into the program by at least two weeks.** The entire provider enrollment process from the receipt of your packet until you transport your first patient should take three months, if your application is submitted in its entirety without the need for correction or request of additional information.

Once you have completed all of the requirements and your application has been approved, it will be sent to one of the Health Standards Field Offices (whichever one is closest to your location) to be assigned to a surveyor for an initial inspection. The Field Office will contact you directly and make an appointment. Under normal circumstances, you should have your initial inspection within four weeks of receipt of your paper work by the field office.

After your inspection has been successfully completed, your results will be faxed back to the Health Standards NEMT Program Desk. Once it is reviewed and approved by the NEMT Program Manager (usually within 24 hours), your application will be forwarded to the Provider Enrollment Unit at Molina Medicaid Solutions. There it will be assigned a provider number. Once processing is completed at Molina Medicaid Solutions, they will notify First Transit to begin giving you trip authorizations. Molina Medicaid Solutions will notify you of your provider number. You are required to read the Medical Transportation manual and become familiar with and knowledgeable of the policy and procedures contained in this manual. This manual can be found at www.lamedicaid.com. On the left side bar the Home page, click on the "Provider Manuals" icon. On the Provider Manuals page, below the Current Manuals heading, select "Medical Transportation" from the drop down box.

With the exception of the criminal background check, the entire process can be done within three months if the proper sequence of events is followed and all of the information is submitted correctly to the Health Standards NEMT Program Desk.

We have also enclosed the necessary forms that you will need to add or change vehicles or drivers once you are in the program. We highly recommend that you keep clean copies of the NEMT Driver Form (HSS-MT-8), NEMT Driver Change Form (HSS MT-8C), NEMT Vehicle Inspection Form (HSS-MT-9), and the NEMT Request for Inspection Form (HSS-MT-15), and its instructions.

Thank you for your cooperation.

Sincerely,

Health Standards NEMT Program Desk

# NEMT REQUEST FOR INSPECTION (Fleet Addition)

TO: HEALTH STANDARDS NEMT PROGRAM DESK
FAX: 225-342-0157 or Email: shelly.tyree@la.gov

COMPLETE ALL NECESSARY BLANKS

Date of Request: _____/_____/_____ Unit Number: _____

State ID: _____

Provider Name: _____ Provider Number: _____

Provider Address: _____

City, State, Zip: _____

Telephone: _____ Fax Number: _____

Contact Person: _____ Email: _____

| Reason | VIN# | Details | |
|---|---|---|---|
| ❑ Addition | | Unit No: _____<br>Yr Model:<br>Make:<br>Color: | Capacity:<br>___ Ambulatory<br>___ Wheelchair |
| ❑ Replacement (check if the additional vehicle replaces an existing vehicle) | | Unit No: | N/A |
| ❑ Windshield Replacement | | Unit No: | N/A |

This vehicle will be ready for inspection on (date): _____

**Attestation Statement**

Under penalty of perjury, I attest that the above listed vehicle is in total compliance with all applicable portions of the Louisiana Motor Vehicle Inspection Act (La. RS 32) and its regulations, and all rules, regulations and pertinent policies and procedures of the Louisiana Medicaid, Non-Emergency, Non-Ambulance, Medical Transportation Program established under provisions of Louisiana Revised Statute 46:450.2.

Provider Signature: _____ Date: _____
Print Name:

**HSS Office Use Only**

Approved by:

_____ Date: _____
NEMT Program Manager Permit #: T_____

*HSS-MT-15 (8/4/99; 12/18/12; 2/13, 3/13, 12/14)*

# NEMT REQUEST FOR INSPECTION (Fleet Addition)

Your Health Standards Regional Office will contact you and schedule an inspection.

## INSTRUCTIONS FOR COMPLETING NEMT REQUEST FOR INSPECTION - FLEET ADDITION "FORM HSS-MT-15"

This form is to be used to addor replace vehicles to your fleet. All additions to your fleet, whether permanent or temporary, must be reported to the Department andpermitted for use prior to the vehicle being used to transport Medicaid clients.If replacing a vehicle please write the VIN# and Unit # of the vehicle being replaced.Please keep copies of this form and these instructions in your files at all times. You may copy the form as needed.

Fill in all blanks on the form with the appropriate information and attach the following documents:

1. The Certificate of Registration from the Louisiana Office of Motor Vehicles showing that the vehicle is registered in thebusiness entity's name & has "for hire" license plates.

2. A copy of your current insurance certificate showing the Vehicle Identification Number of the new vehicle added to your policy. Your insurance agent must follow this up with an original Certificate of Insurance showing that the new vehicle has been added to your policy. **We do not accept Louisiana Automobile Insurance Identification cards.**

3. A NEMT Vehicle Inspection Form (HSS-MT-9A) with section 1 completed.

Fax or email the completed form HSS-MT-15 and the 3 required attachments to the Health Standards NEMT Program Desk. All documents are to be faxed or emailed to this office at the same time. Keep the originals and give them to the surveyor during the inspection of your vehicle.

Pending approval by the NEMT Program Manager, a temporary permit will be faxed to you within two working days of receipt of your vehicle information. Once you receive the permit signed by the NEMT Program Manager, you may begin to use the vehicle. A copy of the permit should remain in the vehicle at all times.

**Please note:** A copy of the Louisiana Public Service Commission Form MT-10 (Affidavit) has been included. If you do not have a "For Hire" waiver from the Louisiana Public Service Commission, you will need to complete this form and submit it to P.O. Box 91154, Baton Rouge, La. 70821-9154 for approval. Once you receive the waiver back from them, you must submit it to the Office of Motor Vehicles in order to obtain your "For Hire" license plate.

If you need additional information,please contact the NEMT Program Desk at 225-342-9404.

# *IMPORTANT Notice:*

***All forms listed on the checklist must be completed and mailed to:***

***Bureau of Health Services Financing***
***c/o Health Standards Section***
***Attention: NEMT Program Desk***
***P.O. Box 3767***
***Baton Rouge, LA 70821-3767***

## *DO NOT:*

- ***Mail the application to the physical address OF Health Standards***

## *DO NOT:*

- ***Mail this application to Molina Provider Enrollment***

**AS THIS WILL DELAY THE ENROLLMENT PROCESS**

Revised 10/14

# Non-Emergency Medical Transportation

## CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that are required in order to enroll in the Louisiana Medicaid Program as an NEMT provider:

| Completed | | Document Name |
|---|---|---|
| ☐ | * | 1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form. |
| ☐ | * | 2. Completed PE-50 Addendum – Provider Agreement Form (two pages). |
| ☐ | * | 3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form. |
| ☐ | * | 4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. **(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)**<br>**Option 1**: Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.<br>**-or-**<br>**Option 2**: If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. |
| ☐ | * | 5. **(If submitting claims electronically)** Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable). |
| ☐ | | 6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted)**. |
| ☐ | | 7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records **(W-9 forms are not accepted)**. |
| ☐ | | 8. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 45 (Non-profit) or Code 46 (Profit). Please note: Providers cannot be classified as non-profit until proof from the IRS is submitted to Molina Medicaid Solutions Provider Enrollment. |
| ☐ | ** | 9. Non-Emergency Medical Transportation (NEMT) License Application Form. |
| ☐ | ** | 10. Notarized Hold Harmless Agreement. |
| ☐ | ** | 11. Driver's Form (MT-8)<br>☐ Copy of Driver's License (either a valid Chauffeur or Commercial).<br>☐ Copy of Defensive Driving Certificate.<br>☐ Copy of Online Driving Record (ODR) Report (available through the Office of Motor Vehicles).<br>☐ Healthcare Provider Criminal Background checks for all prospective drivers. The background checks must be requested through the Louisiana State Police or one of their authorized vendors. (The required form for the background checks is attached for your convenience. Please follow instructions on this form and submit the report/results received back from the State Police when you submit this application/packet to the Health Standards Section for Medicaid enrollment. This form is also available here: http://www.lsp.org/pdf/crauthorizationform.pdf). |
| ☐ | ** | 12. Vehicle Inspection Form (MT-9) for **each** vehicle with Section A completed,<br>***and***<br>☐ Copy of Certificate of Registration for **each** vehicle. |
| ☐ | | 13. Copy of the "For Hire" waiver affidavit received after submitting the completed MT-10 (**) form to the Louisiana Public Service Commission. |
| ☐ | | 14. Proof of Automobile Liability Insurance<br>☐ **Certificate of Insurance** to be submitted now with this application.<br>☐ **Certified copy** of the insurance policy to be mailed directly to Health Standards by the insurance company (not the agent).<br>Note: Insurance Verification Cards are NOT accepted. |
| ☐ | | 15. Proof of Prepayment of Automobile Liability Insurance (contact your insurer to obtain proof that the insurance is paid up 90 days in advance). |
| ☐ | | 16. Proof of General Liability Insurance on the business<br>☐ **Certificate of Insurance** to be submitted now with this application.<br>☐ **Certified copy** of the insurance policy to be mailed directly to Health Standards by the insurance company (not the agent). |
| ☐ | | 17. Proof of Prepayment of (business) General Liability Insurance (contact your insurer to obtain proof that the insurance is paid up 90 days in advance). |
| ☐ | | 18. Notice of Intent to Do Business (copy of the newspaper announcement OR an affidavit from the newspaper confirming that the announcement was published). |
| ☐ | | **19.** Copy of a Municipal License (city permit, business or occupational license that is obtained from the Sheriff's Office Tax Department or the Municipality Finance Office) **and** if the business is located in one of the following parishes:<br>☐ Orleans Parish: Also include a copy of the CPNC (Certificate of Public Need and Conveyance) obtained from the Department of Safety and Permits, Taxicab Bureau.<br>☐ Jefferson Parish: Also include a copy of the NEMT (Non Emergency Medical Transportation) Permit from the Emergency Medical Service (EMS) Office of the East Bank Consolidated Fire Department.<br>☐ Caddo Parish: Also include a copy of the Class B Ambulance Permit, from the City of Shreveport Chief Administrative Officer. |
| ☐ | | 20. Copy of your current business Registration as listed with the Louisiana Secretary of State's Office. This official name must be used as your enrollment name. |

*These forms are available in the **Basic Enrollment Packet for Entities/Businesses.**

** These forms are included here.

*PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS). NO STAPLES.*

*Mail To:*

***Bureau of Health Services Financing, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821-3767, Attention: NEMT Program Desk***

***NO STAPLES PLEASE!***

## NON-AMBULANCE NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ENROLLMENT

Thank you for your interest in becoming a Medicaid provider. Your participation will enable the Medicaid Program to provide more services to a larger number of Medicaid recipients. As a non-ambulance, non-emergency medical transportation (NEMT) provider, you will provide medically necessary transportation to and from Medicaid-approved appointments without cost to recipients who have no other available means of transportation.

These services may be provided via automobile, vans, taxis, and commercial vehicles such as buses and aircraft. Providers will be classified as one of the following types:

√ **Friends and Family Provider** – a friends or family member who will transport recipient(s) to appointment(s) and is enrolled in the NEMT program.

√ **Non-Profit Providers** – business establishments operated by or otherwise affiliated with any public (parish, city, state, or federal) organization. The profits from these business establishments benefit the organization.

√ **Profit Providers** – corporations, partnerships, or individuals who are certified by the Bureau of Health Services Financing and who benefit from the business proceeds.

√ **Taxis** – corporations, partnerships, or individuals who have a state license to operate as a taxi and a permit from the local governing body.

NEMT providers may not subcontract. Profit providers such as nursing homes, Developmentally Disabled (DD) group or community homes, hospitals, etc. may not provide transportation for their own clients and bill Medicaid, but they may bill Medicaid if they transport other Medicaid recipients.

### BASIC NEMT PROGRAM REQUIREMENTS

The Medicaid Program requires that all NEMT providers have (at minimum) auto liability coverage of $100,000.00 per person and $300,000.00 per accident or a combined service limit of $300,000.00. This policy will cover any automobiles (hired automobiles and non-owned automobiles). Providers will have a minimum of $300,000.00 of general liability insurance in the name of the business. Premiums must be pre-paid for a six-month period. Proof of insurance is a notarized, original certificate of insurance which includes the dates of coverage and a 30-day cancellation notification clause. This certificate must be issued to the Bureau of Health Services Financing.

All vehicles used in the NEMT program must be inspected and approved. The vehicles must be properly licensed ("for hire" plates are required on all vehicles except those with "public" license plates). They must have a current state inspection sticker, seat belts, operational air conditioning and heating systems, a child restraint seat, a first aid kit, a PPE kit, a fire extinguisher on board, be safe to operate, and be compliant with pertinent portions of Title 32 of the Louisiana Revised Statutes (Highway Regulatory Act). All vehicles and their required systems such as air conditioning must function in accordance with manufacturers standards.

Providers must comply with all state laws and the regulations of any other governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid Program.

Profit and Non-Profit providers must have either a fax machine or the Blast software capability as determined by the Medicaid Program based on the volume of trips authorized to the provider.

Providers must comply with all applicable federal interstate commerce laws regarding transportation inlcuding, but not limited to, the $1,000,000.00 insurance requirement.

Providers must agree to serve the entire parish or parishes for which he/she provides transportation. (Exception : Providers in Jefferson and Orleans Parishes may choose to serve only the East or the West Bank of the parish.)

Providers are required to immediately report to their area inspector any changes which affect their participation such as fleet size or reduction in the number of parishes covered.

**TRANSPORTATION SCHEDULING SERVICE**

Medicaid will reimburse providers only for approved medical transportation for eligible Medicaid recipients. Additionally, Medicaid recipients will be screened by the transportation dispatch office to determine the need for transportation and the availability of the least costly means of transportation.

Recipients are required to contact the dispatch office in 48 hours advance to schedule appointments. Same-day trips will not be authorized except for certain types of medical necessity. All family members needing to go to the doctor should go on the same day at or about the same time to avoid the need for more than one trip per day. Some recipients may be asked to reschedule appointments to accomplish this. Trips will be schedules using the following heirarchy: city or public transportation (such as buses), friends and family providers, non-profit providers, and then profit providers.

**NOTE:** Transportation providers cannot call dispatch on behalf of the recipient to schedule an appointment. The only medical facilities authorized to fax requests to schedule appointments on behalf of their patients are hemodialysis facilities, long-term care facilities(nursing homes), and KIDMED facilities.

# Denial for Prior Authorization and New Specialized NEMT Codes
## (Memorandum from Thomas D. Collins – November 1, 1994)

Denial for Prior Authorization

After the implementation of the automated prior authorization system, a number of providers experienced problems when billing for NEMT services. These denials and the corrective actions to be taken are as follows:

**"190-Prior Authorization Not on File"** – There is no Prior Authorization number on file at Molina Medicaid Solutions for the recipient for the date of service. In some instances, authorization numbers fail transmission to Molina Medicaid Solutions and do not appear unless Dispatch verifies that an authorization was sent. The claim must be resubmitted once the authorization is submitted by Dispatch and is on file at Molina Medicaid Solutions.

**"191-Requires Prior Authorization"** – There is no match with the authorization number on file at Molina Medicaid Solutions. Many "191" denials stem primarily from instances where the Dispatch Office sends Molina Medicaid Solutions authorization for one procedure code and the provider submits a claim with a different procedure code. For example, a provider agrees to a reduced rate bills the trip as "Z5178" as a negotiated trip, but it should be billed as a "Z5177"-Local Trip even though it is at a reduced rate. A new denial code ("198-Prior Authorization Procedure Not Same as Claim Procedure") will assist in differentiating when the denial is due to the procedure codes on the claim and the prior authorization file not matching. Please note that when a provider has agreed to a reduced rate for a local or capitated trip, the appropriate code for local (Z5177 or Z9498) or capitated trip (Z5179 or Z5180) should be billed, not a "negotiated" trip (Z5178). Negotiated trips should be billed only when the trip is outside the "local area." Please check the billing programs to ensure that the appropriate codes are being used in billing Medicaid. Dispatch must also use the appropriate codes when authorizing trips. If the wrong procedure code is used in the authorization sent to Molina Medicaid Solutions, it must be cancelled and resent by the Dispatch office. "191" denials can also occur if your authorization number is not in the correct place on the claim form. Please check your programming and ensure that the authorization number is appearing in Item 11. Claims previously denied for this error should be corrected as appropriate and resubmitted to Molina Medicaid Solutions.

**"192 – Prior Authorization Has Not Been Approved"** – A request for prior authorization was not approved. This claim cannot be paid and should not be resubmitted.

**"193 – Date on Claim Not Covered By Prior Authorization"** – The date of service on the claim does not have an authorization number even though there may be an authorization number on file for a different date of service for that recipient. If a trip is not made and is made at a later date, it is not acceptable to use the same authorization. Rather, the original number must be cancelled and a new authorization number issued by the Dispatch Office. Once the new authorization number for that date of service is on the file, you may resubmit your claim for payment.

**"194- Claim Exceeds Prior Authorization Limits"** – The authorization number for that recipient for that date of service has already been used to pay for a claim for that trip. You must contact Dispatch to determine if there was an error and an authorization number was used twice; and if appropriate, have a new authorization number sent to Molina Medicaid Solutions.

**"196 – Claim Recipient ID Does Not Match ID on the Prior Authorization File"** – The claim was denied because the recipient number on the claim does not match the recipient number on the Prior Authorization File at Molina Medicaid Solutions. Please ensure that the correct recipient number was used in billing and also that the Dispatch Office used the correct ID in authorizing the trip. Another recipient's authorization number cannot be used for a different recipient even if they are in the same family. An authorization number for each individual must be obtained if several family members are being transported on the same date of service.

**"197- PA Provider ID Not Same as Claim Provider ID"** – The provider number sent by Dispatch to Molina Medicaid Solutions' Prior Authorization file was not the same as that on the claim submitted for that recipient for that date of service. There has been a problem with Dispatch offices using an in-house provider number or an outdated provider number rather than the current provider number

on file at Molina Medicaid Solutions. This results in "197" denials. Please ensure that Dispatch has the correct current provider number. If the incorrect number was used, Dispatch will need to send Molina Medicaid Solutions a new authorization. Once the authorization is resubmitted, the claim should be resubmitted to Molina Medicaid Solutions.

In the future, the Dispatch office will forward to Molina Medicaid Solutions' Prior Authorization file, the following information: recipient name, Medicaid identification number, date of service, procedure code for type of trip, authorization number and amount authorized. The claims processing system will require a match on all of these items to successfully process the claim. Claims that do not match all items will be denied. The Dispatch Offices are being advised of these same findings and asked to correct any errors in the codes or provider numbers they are authorizing.

Claims that were denied should be resubmitted with any necessary corrections. If there are any further problems, please contact your Molina Medicaid Solutions Provider Relations representative to arrange a visit where appropriate corrective actions can be explained.

**New Specialized NEMT Codes Effective for Dates of Service 11/1/94 and After**

The Department has established several additional specialized transportation service codes and rates effective for dates of service November 1, 1994 and after. These are noted below:

**Z5182 – Enhanced Capitated Monthly Rate –** for patient whose capitated trips (for medical services which are regular, predictable and continuing) require more than 5 trips per week (including wheel-chair bound patients who are non-ambulatory).
**Z5183 – Capitated – Remote Rural Monthly Rate –** for patient whose capitated trips for necessary medical services are greater than 120 miles round trip (including wheel-chair bound patients who are non-ambulatory).
**Z5184 – Capitated – Wheelchair – Rural** – for patient in rural area who is wheelchair-bound and non-ambulatory and whose trips are capitated on a monthly basis.
**Z5185 – Capitated Wheelchair – Urban –** for patient in urban area who is wheelchair-bound and non-ambulatory and whose trips are capitated on a monthly basis.
**Z5186 – Local Trip – Profit – Wheelchair –** local trip for a patient who is wheelchair-bound and non-ambulatory.
**Z5187 – Local Trip – Nonprofit – Wheelchair –** local trip for a patient who is wheelchair – bound and non-ambulatory.

Please ensure that necessary programming changes to the billing procedures are completed if needed to reflect these codes. The Dispatch Offices were notified of these new codes at the same time this notice was mailed to providers. The Dispatch Office shall authorize these codes when appropriate. Rates for negotiated trips (Z5178, Z5176, and Z5181) shall take into consideration when the patient is wheelchair-bound and non-ambulatory.

Please note also that the Department is now maintaining complaint files on all NEMT providers regarding failure to pick up recipients in a timely manner before or after medical appointments or arriving too late for appointments. At annual vehicle inspections, the volume of complaints for that provider shall be reviewed and a determination made regarding the provider's continued participation in the program if complaint volume indicates repeated problems with adhering to the NEMT program's regulations (Federal and State). In the event participation in the Program is affected based upon the volume of valid complaints, the Bureau will adhere to existing procedures for due process.

Please contact Molina Medicaid Solutions Provider Relations (225) 924-5040 or the Transportation Program (225) 342-9404 if you have any questions.

DEPARTMENT OF HEALTH
AND HOSPITALS

# Health Standards Section
# License Application
# NON-EMERGENCY MEDICAL TRANSPORTATION

☐ **check if any change has occurred since last application**

**I.** *PROVIDER (DBA) NAME* _____ *EIN#* _____

*GEOGRAPHICAL ADDRESS* _____

*CITY / STATE / ZIP* _____

*TELEPHONE NUMBER* (___) _____ *FAX NUMBER* (___) _____ *EMAIL ADDRESS* _____

**II.** **MAILING ADDRESS** *(IF DIFFERENT FROM ABOVE)* _____

*CITY / STATE / ZIP* _____

**III.** **OWNER'S NAME** _____

**MAILING ADDRESS** (IF DIFFERENT FROM ABOVE) _____

**CITY/STATE/ZIP** _____

**IV. DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION:**

| NON- PROFIT | FOR - PROFIT | GOVERNMENT | |
|---|---|---|---|
| ☐ *INDIVIDUAL / SOLE PROPRIETOR* | ☐ *INDIVIDUAL / SOLE PROPRIETOR* | ☐ *FEDERAL* | ☐ *HOSPITAL DISTRICT* |
| ☐ *CORPORATION* | ☐ *CORPORATION* | ☐ *STATE* | ☐ *COMBINATION GOV-N-PROFIT* |
| ☐ *PARTNERSHIP* | ☐ *PARTNERSHIP* | ☐ *PARISH* | ☐ *OTHER Specify)* _____ |
| ☐ *RELIGIOUS AFFILIATION* | ☐ *GROUP PRACTICE* | ☐ *CITY / PARISH* | |
| ☐ *UNINCORPORATED ASSOCIATION* | ☐ *OTHER (Specify)* _____ | ☐ *CITY* | |
| ☐ *OTHER (Specify):* _____ | | | |

*IF THE DISCLOSING ENTITY IS A CORPORATION, LIST NAMES, ADDRESSES, AND PHONE NUMBERS OF THE DIRECTORS:*

| DIRECTOR'S NAME | ADDRESS | TELEPHONE # |
|---|---|---|
| | | |
| | | |
| | | |

**V.** List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest ( ≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

| OWNER | ADDRESS | TELEPHONE # |
|---|---|---|
| | | |
| | | |

**VI.** ***HOLD HARMLESS AGREEMENT:*** All applicants must execute a Hold Harmless Agreement in favor of the state. The agreement must be notarized. The Hold Harmless Agreement providers must use is provided in the packet.



Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • http://new.dhh.louisiana.gov/

# NON-EMERGENCY MEDICAL TRANSPORTATION
# LICENSE APPLICATION FORM

**...I. *DRIVER REQUIREMENTS:*** Total Number of Drivers Employed: _____

Every driver must complete a Driver Enrollment Form (MT 8), which must be submitted to the Department prior to driving in the program. The MT 8 form is included in this packet.

In addition to the MT 8 Form, you must also include with your application:

1. A copy of his or her chauffeur's license
2. Written verification of successful completion of the appropriate Defensive Driving Course
3. A copy of his or her on-line driver record from the Office of Motor Vehicles
4. Proof that the applicant has applied to the Louisiana State Police or one of their authorized agencies for a criminal history for the driver.

NOTE: All drivers of vehicles enrolled in the NEMT program must:

1. Be 25 years of age or older
2. Hold a valid chauffeur's or commercial driver's license (Louisiana class A, B, C, or D or the equivalent in the driver's state of residence)
3. Successfully complete a defensive driving course recognized by the National Safety Council or its equivalent as determined by the Department

**VIII. *SERVICE AREA REQUIREMENTS:***

The provider service area is defined as the parish or parishes in which the provider had either a main office or a substation. A parish can only be a service area for a provider if he has an office located in the parish and at least one vehicle based there. A provider must accept all trip authorizations within the ...ish or parishes and all reasonable proximity trips to adjacent parishes. List the parish or parishes that you wish to operate the number of vehicles to be ...d in each parish, and the location of the office in each parish.

**NOTE:** The East Bank and the West Bank of Jefferson parish are counted as two separate parishes. You may serve one or the other or both.

| *PARISH* | *NUMBER OF VEHICLES* | *OFFICE LOCATIONS* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**IX. *VEHICLE REQUIREMENTS:***

A participating provider must own or lease all vehicles that will be used to provide NEMT program transportation services. Proof must be submitted indicating that each vehicle(s) is/are registered in the transportation service's name. If the vehicle is under lease, the period of the lease must run concurrently as the inspection period. TRANSPORTATION PROVIDERS MAY NOT SUBCONTRACT.

All information pertaining to the lease or ownership of each vehicle must be listed in the appropriate space on the NEMT Vehicle Inspection Form (MT 9 A & B). The provider is to complete Section I of the MT 9 form for each vehicle participating in the NEMT program and return it with a copy of the vehicle's Certificate of Registration from the Office of Motor Vehicles.

All vehicle certification requirements are listed on the MT 9 form. Every vehicle participating in the program must be inspected and certified to participate in the program every year.

...s must have "Hire Taxi" license plates and vans must have "Hire Bus" license plates.

At the time of enrollment, the provider must stipulate whether each vehicle will be used for services to ambulatory or non-ambulatory recipients.

# NON-EMERGENCY MEDICAL TRANSPORTATION LICENSE APPLICATION FORM

*VEHICLE INSURANCE:*

Providers are required to have minimum automobile liability coverage insurance limits of $100,000 per person and $300,000 per accident or a $300,000 combined single limit policy. The policy shall cover Any Automobiles (schedule 1); or owned, hired, leased and non-owned automobiles (schedules 2 or 4; and 8 and 9). Scheduled automobile policies (Schedule 7) are not permitted.

The insurance company's home office must send the Department a true and correct copy of the insurance policy to verify coverage. The insurance must be prepaid for at least the next three month period. The insurance company must also verify in writing that the policy is prepaid for the next three months.

Providers who intend to transport out-of-state medical appointments must carry $1,000,000 automobile liability insurance in addition to comply with all federal interstate commerce laws pertaining to such transportation. For more information, contact the Public Service Commission.

The Department must be listed as the "Certificate Holder" for all automobile and general liability insurance carried by NEMT providers. This should read as follows on all policies and certificates:

Bureau of Health Services Financing
Health Standards Section
Post Office Box 3767
Baton Rouge, Louisiana 70821-3767
Attention: NEMT Program Desk

The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

The "true and correct copy" of the insurance policy must be mailed directly to Health Standards by the insurance company (not the agent). All policies and certificates must indicate that they cover non-emergency medical transportation vehicles and have an original signature of the insurance company's authorized representatives.

Once the vehicles are inspected and certified for participation in the NEMT program, each vehicle will have a decal placed on it by the surveyor. In addition to initial and periodic recertification inspections, the Department may conduct spot inspections at any time and any location within the state. Any vehicle failing a spot inspection will have its decal removed. The vehicle will have to be inspected again before it can be used again to transport Medicaid clients.

**XI. GENERAL LIABILITY INSURANCE REQUIREMENTS:**

Each Medicaid transportation provider must be covered by general liability insurance on the business, with a minimum coverage of $300,000 combined single limit liability. A "true and correct" copy of the policy must be submitted as part of the enrollment packet indicating the amount of coverage, dates of coverage, etc. This policy must also show BHSF as the certificate holder (see above). Insurance must be prepaid for a three month period. The insurance company must also verify in writing that the policy is prepaid for the next three months.

The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

*XII. LOCAL LICENSE & PERMIT REQUIREMENTS:*

If the provider's city or parish requires a special license and/or permit to operate a medical transportation service, providers must attach a copy of the current license or permit to this form before mailing it to Health Standards. These ordinances exist in Orleans and Jefferson Parishes and the City of Shreveport.

# NON-EMERGENCY MEDICAL TRANSPORTATION
# LICENSE APPLICATION FORM

*TESTATION:*

***It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.***

(NOTE: If Sole Ownership – the owner must sign; If a Partnership - all partners must sign; If a Corporation or Government Entity – the Chief Executive Officer (president, mayor, CEO) and the authorized representative must sign.

_____/_____/____/____/____

*AUTHORIZED REPRSENTATIVE NAME & TITLE (TYPED OR PRINTED/ AUTHORIZED REPRESENTATIVE'S SIGNATURE / DATE SIGNED*

_____/_____/____/____/____

*AUTHORIZED REPRSENTATIVE NAME & TITLE (TYPED OR PRINTED/ AUTHORIZED REPRESENTATIVE'S SIGNATURE / DATE SIGNED*

_____/_____/____/____/____

*AUTHORIZED REPRSENTATIVE NAME & TITLE (TYPED OR PRINTED/ AUTHORIZED REPRESENTATIVE'S SIGNATURE / DATE SIGNED*

_____/_____/____/____/____

*AUTHORIZED REPRSENTATIVE NAME & TITLE (TYPED OR PRINTED/ AUTHORIZED REPRESENTATIVE'S SIGNATURE / DATE SIGNED*

# HOLD HARMLESS AGREEMENT

_____, a medical transportation provider enrolled in the Medicaid Program and providing transportation services for Medicaid recipients, agrees to indemnify, defend, and hold harmless the Department of Health and Hospitals, Bureau of Health Services Financing, from any claims or liabilities whatsoever of any nature arising from the operation of a vehicle by the provider or his employees, agents, etc., and any acts of negligence or misconduct attributable to the provider of his employees, agents, etc.

_____
Provider's Signature

_____
Date

_____
Witness

_____
Witness

_____
Notary Public

| Notary Seal (required) |
| --- |
| |

## NOTICE OF INTENT TO DO BUSINESS

The prospective provider must

- Publish a notice of intent to do business in the newspaper
- Place this notice in the local paper and regional newspaper at least 1 time
- Be sure the newspaper circulates this Notice in his/her geographic area
- Submit a clipping of the actual newspaper Notice or obtain an "Affidavit of Publication" from the newspaper confirming this Notice ran

SAMPLE OF A NOTICE OF INTENT TO DO BUSINESS:

The following is a SAMPLE of what a NOTICE OF INTENT TO DO BUSINESS should look like for the newspaper ad:

## NOTICE OF INTENT TO DO BUSINESS

We are applying to the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030, for approval to enroll in the Medicaid Program as a non-emergency medical transportation provider in the parish(es) of _____. Our business will be located at the following address:

John Doe d/b/a Doe's Transportation Service
11234 Main Street
Baton Rouge, LA 70821

[place proprietor's name at end of notice]

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

# State of Louisiana

## Department of Health and Hospitals

Bureau of Health Services Financing

Monday, March 7, 2011

**MEMORANDUM**

**To:** All NEMT Providers and Applicants

**From:** Steve Erwin, Medicaid Program Manager I-A
Health Standards Section, NEMT Program Desk

**Re:** Criminal History Checks for NEMT Drivers and Providers

Effective, Sunday, August 15, 2010, Louisiana Revised Statutes 40:1300:51 through 56, commonly referred to the "Health Care Provider Criminal Background Check Law" was amended. These amendments change the impact of the statute on non-licensed health care personnel; this includes drivers in the NEMT program.

There are no longer any "waivable offenses" under the law. The law states that persons convicted of certain offenses must be denied employment. For NEMT providers, these offenses include:

Solicitation for Murder
Second Degree Murder
First Degree Feticide
Criminal Assistance to Suicide
Second Degree Battery
Simple Battery to the Infirm
Assault by Drive by Shooting
Mingling Harmful Substances
Forcible Rape
Sexual Battery
Oral Sexual Battery
Aggravated Kidnapping
Human Trafficking
Simple Burglary of a Pharmacy
Armed Robbery
Second Degree Robbery
First Degree Murder
Manslaughter
Second Degree feticide
Aggravated Battery
Aggravated Second Degree Battery
Aggravated Assault
Aggravated Assault with a Firearm
Aggravated Rape
Simple Rape
Second Degree Sexual Battery
Intentional Exposure to AIDS Virus
Simple Kidnapping
Aggravated Arson
Aggravated Burglary
First Degree Robbery
Extortion
Theft of Assets of an Aged Person or a Disabled Person
Crime Against Nature
Cruelty to the Infirm
Aggravated Crime Against Nature
Exploitation of the Infirm

Sexual Battery of the Infirm
Possession with the Intent to Distribute or Distribution of any Schedule 1 through Schedule V Controlled Dangerous Substance

Also included under this statute is any attempt to commit any of these offenses, or conspiracy to commit any of these offenses.

The law applies to all new NEMT drivers hired after August 15, 2010, and anyone who has not been employed by the provider for twenty-four (24) of the previous thirty-six (36) months.

To obtain a criminal history check, you must have the applicant complete and sign a "Louisiana State Police Request for Criminal History" form. After the applicant completes the form, you must submit the form to the Louisiana State Police, Bureau of Criminal Identification and Information with a money order for $ 26.00 (no personal checks). When completing the form, you should check "Health Care Provider" for the type of criminal history check that you are requesting.

NEMT providers will have to obtain criminal history checks on prospective drivers **before** they hire them. The NEMT provider must submit the completed criminal history check to the Health Standards NEMT program desk before that person can drive for the Medicaid NEMT program. This applies to both initial applications, and additional or replacement drivers.

These criminal history checks must come from the Louisiana State Police, or one of their authorized vendors. We do not accept criminal background checks from local police departments, sheriff's departments, or Clerks' of Courts offices.

If you have any further questions, please feel free to call the Health Standards Section, NEMT program desk at 225-342-9404.

## DRIVER INFORMATION & DRIVER CHANGE FORM

A **Driver Information Form (MT-8)** should be completed by each driver upon enrollment and each year thereafter at the annual review. A **Driver's Change Form (MT-8-C)** should be completed and submitted when a driver leaves the employ of a provider, changes the class of his/her license, or changes his/her name or address. Provided below are the instructions for completing each of the forms.

## COMPLETING THE DRIVER INFORMATION FORM

Prior to completing the Driver Information Form, the provider should ensure that all of the information on the prospective driver's operator's license is current and correct. The driver must also have a current Louisiana chauffeur's license (class D). If the driver is employed by a service in a parish bordering the state line and the driver is a legal resident of the adjacent state, the driver may have his/her state of residence's equivalent to a Louisiana chauffeur's license.

The driver's present correct name and address must be reflected on the license. Any drivers needing to change the license information should report changes to the Louisiana Department of Public Safety and Corrections, Office of Motor Vehicles, and have such corrections made prior to completing the form.

Providers should ensure that they fill in the provider name and number. If the provider is in the application process, the provider should write "new" in the blank space. In addition, the provider should fill in the driver's name and address (including city, state, and zip), social security code number, operator's license number, license class, state, and expiration dates, date of birth, race, and sex from the driver's license in the appropriate blanks. The driver's home telephone number should also be entered.

In addition, the provider should check the appropriate block to indicate whether any restrictions apply, and the provider should write an explanation of any restrictions checked.

The provider should indicate whether the driver's license has ever been suspended or revoked and offer an explanation, if applicable. Also, the driver's level of experience transporting people should be explained (how long, by bus, taxi, etc.). If the driver has worked for another NEMT provider, the provider(s) should be listed.

Whether the driver has completed the National Safety Council's or approved equivalent defensive driving course should be indicated. **On-line driving courses will not be accepted.** A driver who has not completed this course will not be approved. In addition, whether a driver has been convicted of any traffic related offense by any court (including pleas of no contest) in the last 10 years should also be indicated. This includes all LA.R.S. 32 offenses (or their equivalent in other states or municipalities), DWIs (LA. R.S. 14:98), reckless operation (L.R.S. 14:99), or vehicular homicide (L.R.S. 14:32.1), vehicular injury (L.R.S. 39.1), or their equivalents.

The form must be signed and dated by the provider and the driver and the following must be attached:

- A legible photocopy of the operator's license (an enlarged copy is preferred)
- A copy of the driver's history obtained from the Louisiana Department of Public Safety and Corrections, Office of Motor Vehicles
- A copy of the Certificate of Completion for a National Safety Council or approved equivalent defensive driving course
- And additional sheets required to complete the form (all additional sheets should be headed with the driver's name, social security number, the provider's name , and the date).
- Proof that you are obtaining a criminal background check for the driver from the Louisiana State Police or one its authorized agencies (a copy of the request plus a copy of the money order paying for the request)

If any information is falsified or credential forged, then monetary sanctions may be imposed; violators will be referred to the Attorney General's Medicaid Fraud Unit for possible criminal prosecution.

**DRIVER'S CHANGE FORM**

This form must be submitted to the Bureau of Health Services Financing within five working days of a change. It should be signed and dated by both the provider and the driver, unless the driver was terminated with cause. All changes of the license must also be signed by the driver, and a copy of the changed license must be attached (this includes license renewals).

Form HSS-MT-8 (revised 2/99)

# DRIVER INFORMATION FORM

1. Provider's Name_____ 2. Provider Number_____

3. Driver's Name _____ 4. SS# ___ - ____ - _____
Last First M.I.

5. Maiden Name (if applicable) _____ 6. Start Date ___/___/___

7. Driver's Address _____
Street City State Zip

8. Driver's Telephone # (___)_____ 9. Driver's Chauffeur License: a. License #_____
b. issue Date ___/___/___ c. DOB ___/___/___ d. Class _____ e. State ____
f. Expiration Date ___/___/___ g. Sex ____ h. Race _____
i. Does license have any restrictions? Y/N If yes, indicate what the restrictions are:

_____

_____

10. Has license ever been suspended or revoked? Y/N If yes, explain:

_____

_____

_____

11. Has driver had experience transporting people commercially? Y/N
If yes, how many years? _____ With whom? _____

12. Has driver ever worked for a NEMT company? Y/N If yes, which company and how long?

_____

13. List the date driver had National Safety Council's Defensive Driving course.
Date of course ___/___/___

14. Has driver eve been convicted of a traffic related offense in the past 10 years? Y/N
If yes, list offense(s) and date with an explanation:

_____

15. Has driver ever been involved in any accident which involved a fatality? Y/N If yes, explain:

_____

16. Has driver ever been on probation or sentenced to jail/prison as a result of a felony conviction or guilty plea? Y/N
If yes, attach a separate sheet giving the law enforcement authority (city police, sheriff, FBI, etc.), the offense, date of offense, place, and disposition of case.

**Your signature on this form is attesting to the validity of this information.**

Driver's Signature: _____ Date:___/___/___

Provider's Signature: _____ Date:___/___/___

Form HSS-MT-8-C (revised 2/99)

# DRIVER'S CHANGE FORM

Provider Information

1. Provider Name_____ 2. Telephone Number (__)_____

3. Provider Number _____ 4. FAX Number (__)_____

5. Address_____
Street City State Zip

**Driver Information**

6. Driver's Name_____ 7. DOB __/__/__ 8. SSN# ___-____-____

9. Address_____
Street City State Zip

10. Type of Change

a. ☐ **Termination**

☐ Voluntary

☐ Involuntary

Reason_____

_____

b. ☐ Modify

☐ Change of Address

From_____
Street City State Zip

To_____
Street City State Zip

☐ *Change of Name*

From_____

To_____

☐ *Change in Class of License*
Copy of new license attached? Circle Y/N

☐ Other _____

_____

**Your signature on this form is attesting to the validity of this information.**

Driver's Signature: _____ Date:__/__/__

Provider's Signature: _____ Date:__/__/__

SUBMIT TO:

**Louisiana State Police**
**Bureau of Criminal Identification and Information**
**P.O. Box 66614 (Mail Slip A-6)**
**Baton Rouge, LA 70896**

*THE FEE FOR PROCESSING A STATE BACKGROUND CHECK IS $26. FOR FBI PROCESSING WHERE AUTHORIZED OR REQUIRED, THERE IS AN ADDITIONAL $19.25 FEE. [EFFECTIVE MARCH 19, 2012 – FBI FEE $16.50] (Cashier Check or Money Order)*

****FORMS MUST BE FILLED OUT IN INK AND BE REVIEWED BY SUBMITTING AGENCY/INDIVIDUAL FOR ACCURACY****
******FINGERPRINTS ARE NECESSARY FOR A POSITIVE IDENTIFICATION******

******PLEASE PRINT******

AGENCY, FACILITY OR INDIVIDUAL

MAILING ADDRESS

CITY STATE ZIP CODE

AGENCY OR FACILITY AUTHORIZED REPRESENTATIVE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

( )
AGENCY OR FACILITY PHONE NUMBER

AGENCY OR FACILITY AUTHORIZED REP E-MAIL ADDRESS

Request For: (pick one only)

- ☐ ALCOHOL AND BEVERAGE COMMISSION
- ☐ ALCOHOL BEVERAGE OUTLET
- ☐ AUTHORIZED AGENCY
- ☐ BOARD OF EXAMINERS OF PSYCHOLOGIST
- ☐ BOARD OF NURSING HOME ADMINISTRATORS
- ☐ CASA
- ☐ COURT ORDER ADOPTION
- ☐ CRIMINAL JUSTICE EMPLOYEE
- ☐ DAYCARE
- ☐ DENTISTRY BOARD
- ☐ DEPARTMENT OF INSURANCE
- ☐ DCFS ABUSE/NEGLECT INVESTIGATION
- ☐ DCFS CARETAKER
- ☐ DCFS FOSTER/ADOPTIVE
- ☐ DCFS PERSONNEL
- ☐ EMPLOYERS
- ☐ FIREFIGHTERS
- ☐ FIRE MARSHAL
- ☒ HEALTH CARE PROVIDER (Non Licensed)
- ☐ JUVENILE DETENTION CENTER
- ☐ LA PHYSICAL THERAPY BOARD
- ☐ LA STATE BOARD SOCIAL WORK EXAMINERS
- ☐ MANUFACTURED HOUSING
- ☐ MEDICAL EXAMINERS
- ☐ OFFICE OF FINANACIAL INSTITUTIONS
- ☐ OFFICE OF PUBLIC HEALTH
- ☐ PHARMACY BOARD
- ☐ POST SECONDARY EDUCATION
- ☐ PRACTICAL NURSING
- ☐ PRIVATE ADOPTION
- ☐ PRIVATE INVESTIGATORS
- ☐ PRIVATE SECURITY
- ☐ PUBLIC HOUSING
- ☐ PUBLIC TAG AGENT
- ☐ REGISTERED NURSING
- ☐ RELIGIOUS ACTIVISTS
- ☐ RIGHT TO REVIEW
- ☐ RIVERBOAT PILOTS
- ☐ SCHOOL
- ☐ SUPREME COURT COMMITTEE BAR ADMISSION
- ☐ TAXI DRIVERS
- ☐ TESS WINDOW TINT
- ☐ USED MOTOR VEHICLE COMMISSION
- ☐ VENDOR
- ☐ WHOLESALE DRUG DISTRIBUTORS
- ☐ WORKING WITH CHILDREN

APPLICANT'S FULL NAME: _____
****PRINT – USE INK****
LAST FIRST MIDDLE
(INCLUDE MAIDEN NAME & PREVIOUS MARRIED NAMES IF APPLICABLE)

APPLICANT'S SIGNATURE: _____

APPLICANT'S SOCIAL SECURITY # ___-__-____ DATE OF BIRTH __/__/__

ID or DRIVERS LICENSE # _____ & STATE _____ RACE ____ SEX ____

POSITION OR LICENSE APPLIED FOR _____

**AUTHORIZATION TO DISCLOSE CRIMINAL HISTORY RECORDS INFORMATION**

By my signature above, I hereby authorize the Louisiana State Police to release all pertinent criminal record information maintained in their files, other states files, or the FBI files (if applicable) which may confirm or deny my eligibility with the facility or agency named above. **DPSSP 6696**
Revised 01/2012

## INSTRUCTIONS FOR FORM MT-9

Form MT-9, the Vehicle Inspection Form, must be completed as follows:

**I. The Provider** must complete the following items in the first section of this form:

- Parish in which the vehicle is stationed
- Provider's name
- Provider number – if the service is new, write "new" in the space provided
- Provider's telephone number – including area code
- The registration (business) name – this name must also be on the Louisiana Certificate of registration;
- Street address of the business, including the city, state, and zip code;
- Unit number – the number that you assign to the vehicle for tracking purposes;
- VIN (vehicle identification number);
- Make of the vehicle;
- Color of the vehicle;
- Model of the vehicle; and
- License plate number and expiration date.

***Note: No vehicle will be inspected without the above completed prior to the inspection.***

**II. Completed by the Inspector**

The remainder of this form is completed by the inspector during the inspection of the vehicle. Details of this inspection can be found in Section 7 on Monitoring and Documentation of provider manual*. After completion of the form, the inspector will have the driver or transportation company representative sign and date the form. Then, the inspector will sign and date the form.

If the vehicle has passed the inspection, the inspector will write the vehicle's decal number in the appropriate space on the form.

The inspector should ensure that the form is readable and give this copy to the driver/company representative.

*Section 7, Documentation and Monitoring, of the provider manual has been included in this enrollment packet following the HSS-MT-9b form.

HSS-MT-9 (Revised 9/03)

# HEALTH STANDARDS SECTION

## *TRANSPORTATION VEHICLE INSPECTION FORM*

**I. GENERAL INFORMATION (to be completed by provider)**

| | |
|---|---|
| **PARISH:** | **UNIT NUMBER:** |
| **PROVIDER NAME:** | **VIN:** |
| **PROVIDER NUMBER:** | **MAKE:** |
| **PROVIDER'S TELEPHONE # (  )** | **YEAR:** **COLOR:** |
| **REGISTRATION NAME:** | **MODEL:** |
| **STREET ADDRESS:** | **LICENSE PLATE NUMBER:** |
| **CITY/STATE/ZIP:** | **LICENSE PLATE EXPIRATION:** |

**II. TYPE OF INSPECTION (to be completed by the INSPECTOR)**

☐ INITIAL ☐ ANNUAL ☐ SPOT CHECK ☐ CHOW

☐ FLEET ADDITION ☐ REINSPECT 1 ☐ REINSPECT 2

**III. VEHICLE INFORMATION (to be completed by the INSPECTOR)**

| | | |
|---|---|---|
| **MVI#**<br>**ODOMETER READING: _____** | **PROOF OF INSURANCE:**<br>**____YES ____NO** | **INSURANCE. EXPIRATION DATE:**<br>**____/____/_____** |
| **STICKER EXPIRES:**<br>**_____/_____** | **VEHICLE CAPACITY:**<br>**Passenger _____W/C__** | **TOTAL DAILY VEHICLE CAPACITY:**<br>**Passenger _____ W/C __** |

**IV. VEHICLE INSPECTION (to be completed by the INSPECTOR)**

**See attached HSS-MT-9b**

**V. RESULTS OF INSPECTION (to be completed by the INSPECTOR)**

☐ UNIT PASSED INSPECTION.

**DECAL NUMBER: _____ EXPIRES: ___/___/___**

☐ UNIT FAILED INSPECTION. PROVIDER MAY REQUEST RE-INSPECTION WHEN CORRECTIONS HAVE BEEN MADE.

**PROVIDERS SIGNATURE** **DATE** **INSPECTOR SIGNATURE**

**INSPECTION OF VEHICLE (to be completed by the inspector)**

*DENOTE OPTIONAL SERVICES

**VIN #**_____

| ITEM | PASS | FAIL | COMMENTS | REINSPECT | | REINSPECT | |
|---|---|---|---|---|---|---|---|
| | | | | PASS | FAIL | PASS | FAIL |
| A1 & 2 BODY & DAMAGE | | | | | | | |
| A3 PROPERLY MARKED | | | | | | | |
| A4 TIRES | | | | | | | |
| A5 LIGHTS | | | | | | | |
| A6 MIRRORS | | | | | | | |
| A7 WINDSHEILD | | | | | | | |
| A8 WIPERS/WASHERS | | | | | | | |
| A9 WINDOWS/DOORS | | | | | | | |
| B1 INTERIOR | | | | | | | |
| B2 HEATER | | | | | | | |
| B3 AIR CONDITIONER | | | | | | | |
| B4 HORN | | | | | | | |
| B5 SEAT BELTS | | | | | | | |
| B6 EXHAUST | | | | | | | |
| C1 FIRE EXTINGUISHER | | | | | | | |
| C2 FIRST AID KIT | | | | | | | |
| C3 PPE KIT | | | | | | | |
| C4 CHILD SEAT | | | | | | | |
| C5 JACK/SPARE | | | | | | | |
| D1 WHEELCHAIR LIFT M/H* | | | | | | | |
| D2 WHEELCHAIR RAMP/TOE* | | | | | | | |
| D3 WHEELCHAIR RESTRAINTS -- TYPE* | | | | | | | |
| D4 TWO WAY RADIO* SYSTEM (HANDICAP V) | | | | | | | |

**COMMENTS:** _____

_____

_____

SURVEYOR: _____

NEMT FIRST AID KIT REQUIREMENTS

The Occupational Safety and Health Administration of the United States Department of Labor has ruled that patient transportation services are subject to its jurisdiction and, therefore, mandates that all such vehicles are required to have a first aid kit on board. The first aid kit should contain, at a minimum, the following:

- ☐ Plastic Strips ¾" X 3"
- ☐ Adhesive Tape ½'' X 5 yards
- ☐ Gauze Bandage 1''
- ☐ Gauze Bandage 2"
- ☐ Non-adherent Pads 2" X 3"
- ☐ Oval Eye Pads 2" X 3"
- ☐ Cold Pack
- ☐ Bagged Pair of Latex Gloves
- ☐ Butterfly Bandages Med
- ☐ Fabric Strips ¾" X 3"
- ☐ Triangular Bandage
- ☐ Ammonia Inhalants
- ☐ Antiseptic cream or ointment 7/8 oz. tube
- ☐ Antiseptic Wipes
- ☐ Scissors
- ☐ Personal Protective Equipment Kit (see below)*

*NOTE: These items will be checked during inspection.*

* 29 CFR 1910 OSHA mandates personal protective equipment kit for all patient transportation services. In order to be in compliance with this section, vehicles must carry a PPE protection kit that includes rubber gloves, an impervious gown or coveralls, shoe covers, a face mask and safety goggles or a fluid shield. N-95 or N-100 masks are also highly recommended.

## Insert from Provider Manual - Section 7, Documentation and Monitoring

A valid motor vehicle inspection sticker issued by the state of Louisiana or one of its municipalities must be displayed.

I. Providers must verify that:

- The correct VIN is on all paperwork (match it to the vehicle);
- The registration certificate is valid and that all information is current and correct; and
- The vehicle has a valid Louisiana license plate and MVI sticker (LA or municipalities) properly displayed.

II. The inspector will inspect the exterior of the vehicle for the following:

- **Body and Damage** – No appreciable body or paint damage or missing pieces.
- **Properly Marked** – All vehicles must have the service name and telephone number displayed in 2' letters (or greater) on the driver and passenger doors. Vans must also have this marking on the back door. Lettering must be painted, shown as a decal, or otherwise permanently attached (no magnetic signs). The color of the lettering must be in contract to the car's paint color. The unit number must be displayed in 2' numbers (or greater) on the right and left front quarter panels adjacent to the doors in the corner where the hood, door, and windshield meet. The number must also be displayed in the left lower back glass, affixed from inside the glass. Providers in Orleans Parish must use their Orleans Parish CPNC number as their unit number. It must meet Orleans Parish Regulations for size, contrast of color, and location.
- **Tires** – Tread in accordance with RS32 – No exposed wire, bubbles, or appreciable sidewall damage.
- **Lights** – Check headlights (high and low beams), turn signals, hazard flashers, back-up lights, brake lights, and parking lights.
- **Mirrors** – Must have left-hand outside rear view mirror and inside rear view mirror and a right-hand outside rear view mirror.
- **Windshield** – Perform paper test (8 ½" X 11" sheet held horizontally steering wheel) on windshield in driver's view and ensure that there are no stars or cracks.
- **Wipers/Washers** – Ensure that wipers and washers are functioning properly.
- **Windows/Doors** – All windows and doors must function as intended by the manufacturer.

The inspector will inspect the interior of the vehicle for the following:

- **Interior Compartment** – Ensure that the interior compartment is free from tears, holes, large stains, or offensive odors. Everything in the passenger compartment must be secure. No sharp edges, points, or other hazards are allowed in the patient compartment.

The inspector will also ensure that the vehicle contains the following equipment:

- **Fire extinguisher**
- **NEMT approved first aid kit**
- **PPE kit**
- **Child Seat**
- **Jack/Spare tire**

- **Heater** – Ensure that the heater is functional and that air at the vent is warm to the touch in accordance with manufacturers' standards.
- **Air Conditioner** – Ensure that the air conditioner is functional and that air at the vent is cool to the touch, in accordance with manufacturers' standards.
- **Horn** – Ensure that the horn functions properly
- **Seat Belts** – Functional and undamaged for all seats

The requirements for the first aid kit and PPE kit are provided on the checklist after the inspection form. Providers should ensure that each vehicle contains a minimum 2 B: C fully charged fire extinguishers within the driver's reach in the passenger compartment. All of these items must be marked with the unit number. Halon extinguishers are not permitted.

The inspector will also ensure that the vehicle contains a secured jack capable of raising a tire from the ground and an inflatable spare, in accordance with the previously mentioned tire standards.

The inspector will ensure that wheelchair vans contain the additional operating requirements listed below:

- **Lift, Manual or Hydraulic (either acceptable)** – Check for leaks, ease of operation, and panel markings (up and down). Check electrical cords for frayed or torn wiring and proper connections. Check for proper up and down operation.
- **Ramp with Toe Cleats 28" Wide** – Assure proper size
- **Wheelchair Restraints** – May use lock, well, and tiedown system or ratchet system. Either system must be bolted to the bottom of the vehicle, in accordance with the manufacturer's recommendation. If locks are used, they must have pins, and both rear wheels of the wheelchair must be secure..
- **Two – way Radio Systems** – Ensure that the two-way radio system is in working order.

The inspector will complete the bottom of the form as follows:

- Write his/her narrative based on items needed. A supplemental form should be attached, if necessary.
- Check whether the inspection is classified as an enrollment, fleet addition, recertification, or spot check inspection.
- Check whether the vehicle has passed or failed the inspection.
- Have the driver or company representative sign and date the form.
- Sign and date the form.
- If the unit passes inspection, the inspector will write the vehicle's decal number in the appropriate space.
- Ensure that the writing is readable on the form and give a copy to the driver/provider.

## PROCEDURES TO OBTAIN FOR HIRE PLATES

The Department of Public Safety began requiring all Non-Emergency, Non-Ambulance Medical Transportation vehicles to have a "For Hire" license effective July 1, 1993. To obtain this license plate, the provider must:

1. Complete the attached affidavit (MT-10).

2. Have the MT-10 notarized and mail or return it to:

**Public Service Commission**
**P.O. Box 91154**
**Baton Rouge, LA 70821**

3. Upon receipt of the license approval certificate from the Office of Public Service Commission, make copies of the originals and keep them for future use.

A copy of the license certificate is to be presented to the Department of Motor Vehicles to obtain your "For Hire" license plate. One copy of the license certificate is required for each vehicle. This certificate is to be used exclusively for commercial Non-Emergency Medical Transportation vehicles only.

"For Hire" plates are to be obtained after you have been assigned a provider number. A regional transportation inspector will contact you with the provider number and advise you to obtain the "For Hire" plates at that time.

# AFFIDAVIT

STATE OF LOUISIANA

PARISH OF _____

Before me, the undersigned authority, this date personally came and appeared:

_____, whose company name is _____
(Affiant/Provider's Name) (Affiant/Provider's Company Name)

who, after first being by me _____;
(Printed Notary's Name)

duly sworn, deposes and says:

That he/she is engaged in the business of transporting by motor vehicle PASSENGERS for compensation, but that he/she is exempt from the provisions of act 301 of Louisiana Legislature of 1938 as amended by Act 20 of Louisiana Legislature of 1946 for the following reasons: Both provider (carrier) owned and leased vehicles will be used exclusively for commercial non-emergency medical transportation only, pursuant to LRS 45:172 A (3). The license approval certificates supplied to me by the Louisiana Public Service Commission will be used to purchase license plates for this purpose only. All license plates are to be purchased/issued in the provider's name.

_____ _____
PRINTED NAME OF WITNESS SIGNATURE OF AFFIANT/PROVIDER

_____ ADDRESS: _____
SIGNATURE OF WITNESS

_____

PHONE (_____) _____-_____

Subscribed in my presence and sworn to before me by the affiant above-named this

_____day of _____, 20_____.

_____
(Notary's Signature, Seal & Notary Number)