THE TRANSPORTATION NETWORK

Getting You from Where You Are to...Where You Want to Be!

SHUTTLE SERVICES VENDOR APPLICATION

To avoid delays, please check the following to ensure your application is accurate and complete before submitting to: info@thetransportationnetworks.com

1. Is all provider information completed?
2. Is there a copy of up-to-date insurance coverage attached?
3. Is your business license attached?
4. Is the application signed and dated?

SECTION 1:	**COMPANY INFORMATION** if multiple locations, please attach a separate list of all applicable service locations, addresses and contact information			
LEGAL NAME:		**DBA:**		
CORPORATE STREET ADDRESS:	**CITY:**	**STATE:**	**ZIP:**	**COUNTY:**
MAIN PHONE: / **SECONDARY PHONE:**	**EMAIL:**	**TAX ID #** (Federal or SS if sole proprietor)		
MAILING ADDRESS (if different):				
CITY:	**STATE:**	**ZIP:**	**COUNTY:**	

SECTION 2:	**BUSINESS CONTACTS**		
NAME:	**TITLE:**	**PHONE:**	**EMAIL:**
NAME:	**TITLE:**	**PHONE:**	**EMAIL:**
NAME:	**TITLE:**	**PHONE:**	**EMAIL:**

SECTION 3:	**HOURS OF OPERATION** Our system will not schedule a trip within one hour of start / stop time.		
REGULAR HOURS (Office Open)	**MONDAY - FRIDAY**	**SATURDAY**	**SUNDAY/HOLIDAYS**
TRANSPORT HOURS	**MONDAY - FRIDAY**	**SATURDAY**	**SUNDAY/HOLIDAYS**

SECTION 4:	**TYPES OF SERVICES PROVIDED** Please provide the Types of services and the number of vehicles regular utilized for services					
STANDARD VEHICLES	**SEDANS:**	**# PASSENGERS**	**MINI-VANS:**	**# PASSENGER**	**OTHER:**	**# PASSENGERS**
SPECIALTY VEHICLES	**MINI-BUS:**	**# PASSENGERS**	**CHARTER BUS**	**# PASSENGERS**	**OTHER:**	**# PASSENGERS**

MEDICAL VEHICLES	**WHEELCHAIR:** (Para Lift):	**WHEELCHAIR BARIATRIC:** (Para Lift over 400 lbs.)	**STRETCHERS:**
ADDITIONAL COMMENTS:			

SECTION 5:	**SERVICE AREA** Please list by County and provide a detail list of zip codes you would like to receive trips.		
COUNTY	**WAYNE**	**OAKLAND**	**MACOMB**
ZIPS			
ZIPS			

1.	What is the maximum number of roundtrips per hour by vehicle type are you willing to accept within your service area?				**1**
2.	Are you willing to accept trips outside of your local area if need arise?	YES		NO	
3.	Are you willing to accept round-trip last minute/same day request?	YES		NO	
4.	Will you agree to place a phone call or text each rider informing them of pickup times and to confirm pickup arrangements?	YES		NO	
5.	What is your primary communication system with Vehicles/Drivers? *Please check all that apply?* CELL PHONE X MOBILE DATA TERMINAL (Computer) NONE				
	If none would you consider a form of vehicle/driver communication?	YES		NO	

SECTION 6:	**HUMAN RESOURCES AND OTHER ASSETS**					
1.	Will your drivers assist ambulatory members if necessary (i.e. frail and/or elderly individuals)? *If Yes, please indicate specific assistance (check all that apply)*				YES	NO
	____To/From Door	____ Up/Down Steps	____ In Elevator	____ To Check-In Desk		
2.	Will your drivers assist wheelchair members if necessary?				YES	NO
3.	Will your drivers assist wheelchair members if necessary?				YES	NO
	_____ To/From Door	_____ Up/Down Steps	_____In Elevator	___ To Check-In Desk		
4.	If you use sedans, will you transport a person in a wheelchair, who is capable of scooting from the chair to the vehicle and then place folded wheelchair in the trunk? (This is not appropriate for van use if the wheelchair is not properly stowed because it can become a flying, harmful object in the event of a collision.)				YES	NO
5.	Can you provide attendants to stay with rider during the entire medical appointment? (if necessary)				YES	NO
6.	Do you contract with an organization that provides attendants?				YES	NO
7.	Do you provide child restraint seats?				YES	NO
	If no, would you consider purchasing car seats (as needed)?				YES	NO

SECTION 7:	COMPANY CERTIFICATION					
	Does your business qualify for your State's "Minority Owned Business Enterprise" (MBE)?	YES		NO		
	(Note MBE usually means U.S. citizens(s), a sole proprietorship, partnership, corporation or joint venture; owned, operated, and controlled by a minority group member or members who have at least 51 percent ownership. The minority is generally defined as belonging to one of the following racial minority groups: African American, Native American, Hispanic American, Asian American or other similar groups).					
	If yes, is your company a Certified MBE? If so, please provide us with a copy of your certificate.	YES		NO		
	If not, are you interested in becoming certified?	YES		NO		
2.	Does your business qualify for your State's "Women-Owned Business Enterprise" (WBE)? (Designation not available in all states; description is above; replace "woman" with "minority").	YES		NO		
	If yes, is your company a Certified WBE? If so, please provide us with a copy of your certificate.	YES		NO		
	If not, are you interested in becoming certified?	YES		NO		
3.	Federal Tax ID Number / SS#?					
	Non-Profit Tax Exempt # (if not for profit)					
4.	What is your state / commonwealth Medicaid Provider #?					
	Mandatory information if Medicaid provider # has been assigned to your company.					

SECTION 8:	COMPANY INSURANCE Please attach cover sheets or insurance certificates to this application		
	INSURANCE TYPE	INSURANCE COMPANY	LIMIT AMOUNT (per occurrence /aggregate $
1.	Vehicle Liability		
	Personal Liability		
	Workman Compensation		

SECTION 9:	LEGAL INFRACTIONS For any yes answers, please provide a full and complete explanation of a separate sheet of paper. A yes answer, does not necessarily constitute disqualification for consideration.					
2.	Have there ever been any liability (i.e. malpractice, commercial, or vehicle) claims, suits, judgements, settlements or arbitration proceedings brought against (you) your company or currently pending involving (you) your company	YES		NO		
3.	Have (you) your company (or any employee that will provide services for us) ever been suspended, fined, disciplined, investigated, expelled, sanctioned, or otherwise restricted or excluded from participation in any private, federal, or state health insurance program (i.e. Medicare, Medicaid) or any of the such proceedings against you or them?	YES		NO		
4.	Have you or any employee that will provide services for TTN ever been disciplined or sanctioned by any professional licensing body or accrediting organizations, or any such proceedings in progress against you / them?	YES		NO		
5.	Have you (or any employee that will provide services for TTN) ever been convicted of, pled guilty to, or pled not guilty to any felony that is reasonably related to your qualifications,	YES		NO		

	competence, functions or duties of the services that will be provided or currently under indictment or currently have pending any charges?				
6.	Have you (or any employee that will provide services for TTN) ever been convicted of, pled guilty to, or pled not guilty to any felony that alleged fraud, or an act of violence, child abuse, patient abuse, or sexual misconduct, or are currently under investigation or indictment, or currently have pending any such charges?	YES		NO	

SECTION 10:	**APPLICANT SIGNATURE**

The undersigned Provider certifies that the above information is true and complete. It is further certified that the service specified above will operate in conformity to the requirements of all local, state and federal regulations. The undersigned Provider hereby consents to its (including any of its principals or employees) background being checked by TTN and /or its agent. Providers consents to the disclosure, inspection and copying f information and documents related to Provider's qualifications for evaluating this application. Provider is informed and acknowledges that federal and state laws provide immunity protection to certain individuals and entities for their acts and/or communications made in good faith in connection with evaluating the qualifications of Providers. Provider hereby, releases all persons and entities, including TTN, their representatives and all persons and entities providing information to TTNR, from any liability they might incur for their acts and/or communications in connection with evaluation of Provider's qualifications for Network participation, including any decision to admit or deny Providers application. Provider understands and agrees that Provider, as an applicant, has the burden of producing adequate information for proper evaluation of Provider's qualifications for Network membership. The undersigned hereby affirms that the information submitted in this application and any addenda thereto is true, current, correct, and completed to the best of their knowledge and belief and is furnished in good faith. Provider agrees to provide TTN with any updated information in the event of any change in the information set forth in this application.

Applicant Signature	**Title**	**Date**

By signing this application, the Transportation Provider acknowledges that it, as well as any employee or contract employee, is not listed on the U.S. Department of Health Human Services' Extended Provider list for federal health care programs. Under no circumstances shall any such excluded provider be allowed to provide services in our Network.

Please double-check the following to ensure all information is accurate and complete. Email to: ttninc@outlook.com

1. Is all provider information completed?
2. Is there a copy of up-to-date insurance coverage attached?
3. Is your business license attached?
4. Is the application signed and dated?