Transportation Network Development
2602 S. 47th Street
Phoenix, AZ 85034
Fax (866) 913-4397

LOGISTICARE PROVIDER NETWORK QUESTIONNAIRE

Please provide all the requested information to the best of your ability via fax **AND** mail the original.
If you need more space, please write on the back or attach a separate sheet. Thank you.

COMPANY CONTACT INFORMATION

COMPANY NAME: ____

STREET ADDRESS: ____

MAILING ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________________

PHONE: __________________________ FAX: __________________________

EMAIL: ______________________________ WEB SITE : ______________________________

Which of the following best describes your company? Private____ Not for Profit_____ Taxi _____ Transit Agency______

Human Services Agency_____ Agency on Aging _____ Faith Based Organization______

NAME OF PERSON AUTHORIZED TO ENTER COMPANY INTO CONTRACTUAL OBLIGATIONS:

NAME: ____________________________________TITLE: ______________________

PHONE #: ____________________FAX:____________________EMAIL:____________________

BASIC OPERATIONS INFORMATION

In what State do you operate? ____

How many total vehicles do you operate in the state? __________________________________

How many vehicles do you operate per county by type (Total must equal number above)? Please fill below:

County	Sedan – Non Taxi	Taxi	Mini Van	Full Size Van	ADA Wheelchair Van	Non-emergency Stretcher/Gurney	BLS Ambulance	ALS Ambulance	Other (please specify)
Please complete with number of vehicles by type in each county									

How many drivers do you employ? ______ How many office personnel? ______ How many other? ______

Please describe your hours of operation:

	Hours of Operation	
Day	From:	To:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

What type of 2-way communication system do you use to talk to your drivers? ___________________________________

____

Please describe your routing and dispatch technology and procedures: ____

____

____

____

Please describe your vehicle insurance coverage limits:____

____

MEDICAL TRANSPORTATION EXPERIENCE

Do you currently provide Non-Emergency Medical Transportation (NEMT) Services? ___________

Please list all local, state or other permits or licenses you hold. ____

Are you licensed as an ambulance service? ___________

Have you ever been terminated from a State/Federal program or convicted of Medicaid/Medicare fraud? ________________

Approximately how many *WEEKLY* one-way MEDICAL trips do you currently provide? ___________ Other? __________

If you would like to increase this amount, what number of *weekly one-way* trips would you like to provide? _____________

How many additional vehicles would you need to manage that level of operation? __________________________________

Are you able to offer services in a language other than English? If yes, please indicate the language: ___________________

If you currently provide NEMT services, please list the facilities you currently serve. (Attach separate list if needed)

____

____

DRIVER MANAGEMENT

Please describe your driver hiring and screening process: ______________________________

____

____

Please describe your driver training and evaluation process: ______________________________

____

____

QUALITY ASSURANCE PROGRAM

What steps do you take to monitor and ensure the timeliness, safety, and sensitivity of your transportation services?

____

____

____

____

DWMBE STATUS

If your company qualifies, or is certified as one of the following please check the appropriate box and complete the attached DWMBE questionnaire.

Type	Check	Designation	Ownership Definition
SBE		Small Business Enterprise	Business with less than 500 employees
MBE		Disadvantaged Business	Business with 51% or more certified defined US minority ownership
WBE		Woman Owned Business Enterprise	Business with 51% or more certified woman ownership
VET		Veteran Business Enterprise	Business 51% or more certified US military veteran owned
DVBE		Disabled Veteran Business Enterprise	Business 51% or more certified disabled US veteran owned
DBE		Disabled Business Enterprise	Business 51% or more certified disabled persons owned

OTHER COMMENTS OR CLARIFICATIONS: ______________________________

____

____

COMPLETED BY: ______________________ **TITLE:** ______________________

E MAIL: ______________________ **TELEPHONE**: ______________________

DATE: ______________________

PLEASE FAX FORM TO 866-913-4397, AND MAIL ORIGINAL
ATTENTION: NETWORK DEVELOPMENT
Email questions Network@logisticare.com