HOMELINK Transportation CREDENTIALING APPLICATION

***Control Number:** ☐

A Control Number must be included in the box above in order for HOMELINK to process your credentialing application. The Control Number is located in the faxed cover letter or email you received with instructions for downloading this credentialing application. If you are a new HOMELINK provider completing a credentialing application for the first time, please enter X12345 in the Control Number box above. Contact the HOMELINK Credentialing Department by phone at 866-575-8482 or email at HomelinkCredentialing@vgm.com if you have any questions.

Legal and Main Contact Information		
Legal Company Name[1]:		
Practice/DBA:		
Address:		
City:	State:	Zip Code (9 digit):
Main Phone #:	Alt Phone #:	
Fax #:		
Federal Tax ID #: *(attach a copy of W-9)*		
Credentialing Contact Name:	Credentialing Contact Phone #:	
Credentialing Contact Email Address:		
Do you have access to the internet: ☐ Yes ☐ No		
Website Address:		
Is your company a Minority Business Enterprise (MBE)? ☐ Yes ☐ No		
Is your company a Women Business Enterprise (WBE)? ☐ Yes ☐ No		
Is your company a Veteran-Owned Business? ☐ Yes ☐ No		

[1]HOMELINK is unable to contract with and/or credential Applicants who are individuals. HOMELINK requires Applicant to provide evidence that it is a legal business entity (i.e., an LLC or Corporation) organized and in good standing under applicable state law state. A local business license is not sufficient. To maintain status as a provider in HOMELINK's network, HOMELINK may require that Applicant periodically provide proof that it remains active and in good standing under applicable state law.

Primary and Additional Facility Locations

Please complete below for Primary Company facility location and copy this page and complete for each additional facility location. All changes must be communicated within 15 business days of change to homelinkcredentialing@vgm.com.

Facility Name:		
Address:		
City:	State:	Zip Code (9 digit):
County:		
Phone #:	Fax #:	
Contact Name & Title:	Contact Phone #:	
Contact Email Address:		
Referral Email Address:		
Medicare #	(***attach a copy of Medicare Enrollment Letter)***	
Medicaid #:		
Business License #:	State License #:	
Federal Tax ID #:	***(attach a copy of W-9)***	
NPI # *(If applicable):*		
State Sales Tax #:	(***attach a copy of Sales Tax Certificate)***	
Total Number of Employees:		
Preference for receiving appointment confirmations:		
Phone # for report request:		
Languages: ☐ English ☐ Spanish ☐ Other *(list all other languages)*:		
Do you have centralized scheduling? ☐ Yes ☐ No Phone #:		
Office Hours (M-F):	Saturday Hours: Sunday Hours: Holiday Hours:	24 Hour On-Call/After-Hours Coverage: ☐ Yes ☐ No

Please Check ✓ the Transportation Services Provided at the Above Location

☐ Ambulatory ☐ Wheelchair Van ☐ Stretcher/Gurney ☐ ALS Ambulance ☐ BLS Ambulance ☐ Sedan ☐ Limousine	**Service/Coverage Areas:**

☐ Please attest by checking this box that all appropriate training is provided to staff for all services marked above.

Billing/Remit Addresses		
Address:		
City:	State:	Zip Code (9 digit):
County:		
Main Phone #:	Alt Phone #:	
Fax #:		
Billing Contact Name:	Billing Contact Phone #:	
Billing Contact Email Address:		

☐ **Check the box if the billing/remit address applies to all facility locations**

General Information	
Is Applicant required to have a Medical Transportation Service Certificate? ***If yes, please attach a copy of all current Medical Transportation Certificates.***	☐ Yes ☐ No ☐ NA
Is Applicant's organization required to have a state license to provide services? ***If yes, attach copies of each current license with expiration dates.***	☐ Yes ☐ No
Is Applicant's organization required to have a business license to provide services? ***If yes, attach copies of each current license with expiration dates.***	☐ Yes ☐ No
Does Applicant currently own any Foreign Assets, Companies, and/or Offices? ***If yes, attach a copy of your W-8.*** ***HOMELINK's policy is not to engage in any services or financial activity with any individual or entity that has or has been suspected to have direct or indirect ties with terrorism.***	☐ Yes ☐ No
Does Applicant subcontract any services? ***If yes, who credentials these subcontractors?_____*** ***If yes, provide a list of individuals and/or entities that you subcontract with along with a list of services these individuals and/or entities are subcontracted for.***	☐ Yes ☐ No
Does Applicant's drivers use their own vehicles?	☐ Yes ☐ No
Does Applicant allow its drivers to also drive for Lyft and/or Uber?	☐ Yes ☐ No
Is Applicant's organization currently registered for MN-ITS and MTM credentialed? ***(Minnesota Medicaid Transportation Providers only)*** ***If yes, please provide evidence of current registration and approved credentialing.***	☐ Yes ☐ No

Insurance Information

Commercial General Liability Coverage (CGL)?	☐ Yes ☐ No
Professional Liability Coverage?	☐ Yes ☐ No
Commercial Business Auto Liability Coverage?	☐ Yes ☐ No
Aviation Liability Coverage?	☐ Yes ☐ No

Applicant agrees to keep in full force and effect and maintain at its sole cost and expense the following policies of insurance:

a. Commercial General Liability Coverage (CGL) – None required
b. Professional Liability/E&O – $1 million per occurrence / $3 million aggregate*
c. Commercial Business Auto Liability Coverage - $250,000 per person / $500,000 per accident
d. Aviation Liability Coverage - $10 million**

Only if required by state law or regulation or contractually for Advance Life Support (ALS), Basic Life Support (BLS), Stretcher, and Wheelchair transports.
****Only required for air ambulance transports.***

Applicant shall, at its own cost and expense, procure and maintain policies of CGL, Professional, Commercial Business Auto, and Aviation Liability insurance as required in the state where the Applicant offers Covered Services, in minimum coverage amounts in accordance to above, minimum coverage amounts, or if greater, in minimum coverage amounts required in the state where Applicant offers covered services, to insure Applicant and its employees against claims for damages arising by reason of personal injury, loss or death resulting directly or indirectly from or in connection with the performance of any covered services by Applicant, its employees and agents.

Attach a copy of Applicant's CGL, Professional Liability, Commercial Business Auto, and Aviation Liability Certificate of Insurance including amount of coverage. Applicant must list HOMELINK as an Additional Insured on all CGL, Professional, Commercial Business Auto, and Aviation Liability policies.

Applicant is responsible for any insurer fees for adding HOMELINK as an additional insured on Applicant's applicable insurance policies**.**

Applicant attests that the above policies of insurance are currently in force at or above the established coverage limits. ***Failure to meet the above minimum insurance coverage requirements will result in denial of this application.***	☐ Yes ☐ No

Applicant shall, except where a new policy is secured and no lapse in coverage occurs, provide HOMELINK with written notification of any cancellation, termination, expiration or alteration of any such policies within twenty-four (24) hours after provider receives notice of such change in policies.

Applicant must send HOMELINK updated copies of your Certificates of Insurance when renewed each year.

Has Applicant's CGL coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years? ***If yes, attach a copy of any CGL adverse actions for the past five (5) years.***	☐ Yes ☐ No ☐ NA
Has Applicant's Professional Liability coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years? ***If yes, attach a copy of any Professional Liability adverse actions for the past five (5) years.***	☐ Yes ☐ No ☐ NA
Has Applicant's Commercial Business Auto coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years? ***If yes, attach a copy of any Professional Liability adverse actions for the past five (5) years.***	☐ Yes ☐ No ☐ NA
Has Applicant's Aviation Liability coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years? ***If yes, attach a copy of any CGL adverse actions for the past five (5) years.***	☐ Yes ☐ No ☐ NA
Has Applicant ever had any professional liability actions settled, arbitrated, mediated or litigated?	☐ Yes ☐ No ☐ NA

Disclosures ***If you respond Yes to any of the following questions below, please attach a summary of any legal actions, adverse sanctions, disciplinary actions, etc., signed by owner.***	
Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever been convicted of a felony or misdemeanor other than minor traffic violations?	☐ Yes ☐ No
Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever been excluded from participation in Medicare or any of the state health care programs, such as Medicaid?	☐ Yes ☐ No
Have you or any owner, officer, director, employee, agent, and/or subcontractor (including your organization) ever been on the OIG's LEIE, SAM, and/or State Medicaid exclusion lists? ***(This information will be verified.)***	☐ Yes ☐ No
Does your organization perform monthly OIG LEIE, SAM, and/or Medicaid exclusion verification checks on your owners, officers, directors, employees, agents, and/or subcontractors? ***(You may be asked to provide verification of this at any time.)***	☐ Yes ☐ No
Has your organization ever been refused participation from, not renewed or terminated for cause, or been subject to disciplinary action, by any managed care or provider organizations (including HMO's, PPO's, IPA's or PHO's)?	☐ Yes ☐ No
Has your organization ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted from participation in federal or state government healthcare plans or programs including Medicare and/or Medicaid?	☐ Yes ☐ No
Has your state and/or business license(s) ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restricted?	☐ Yes ☐ No
Do you perform drug testing on your drivers? ***If yes, how frequently?_____*** ***If no, please provide explanation:_____*** ***_____***	☐ Yes ☐ No
Does Applicant use offshore subcontractor services such as billing, customer service, etc.? ***HOMELINK must approve the use of any offshore subcontractor.***	☐ Yes ☐ No

Attestations

All applicable documents in this section must be provided to HOMELINK, upon request, within two (2) business days or sooner if required by a payer or accreditation organization.

Applicant attests to compliance with the Section 1557 of the Affordable Care Act of 2010, in regards to ensuring that individuals with disabilities and/or limited English proficiency have access to its applicable materials and services.	☐ Yes ☐ No ☐ NA
Applicant attests to performing multi-state jurisdictional criminal background checks, fingerprints, and/or drug screens on owners, officers, directors, employees, agent, and/or subcontractors in accordance with federal, state, and local law, and having an established written policy outlining the screening procedures.	☐ Yes ☐ No ☐ NA
Applicant attests to having procedures in place for the verification and monitoring of valid multi-state jurisdiction motor vehicle licenses and driving histories of employees and subcontractors. Applicant also attests that all drivers have valid motor vehicle licenses and have a driving history of three (3) or fewer moving violations. ***(Copies must be made available to HOMELINK upon request)***	☐ Yes ☐ No ☐ NA
Applicant attests to holding all applicable organizational licensure, endorsements, permits, registrations, and/or accreditations that are current, active, and in good standing, in accordance with state and/or local law.	☐ Yes ☐ No ☐ NA
Provider attests to having adopted and is currently adhering to a drug-free and alcohol-free workplace written policy and program. ***If no, provide an explanation:_____***	☐ Yes ☐ No ☐ NA
Applicant attests to having a Sales Tax Certificate.	☐ Yes ☐ No ☐ NA
Applicant attests to having Human Resources policies and procedures.	☐ Yes ☐ No ☐ NA
Applicant attests to having a current Patient Satisfaction Survey with results.	☐ Yes ☐ No ☐ NA
Applicant attests to having a current Quality Assurance and Performance Improvement (QAPI) Program.	☐ Yes ☐ No ☐ NA
Applicant attests to having HIPAA Privacy and Security policies and procedures and to conducting employee and subcontractor training as required by state and federal law.	☐ Yes ☐ No ☐ NA

The Health Insurance Portability and Accountability Act (HIPAA) Security Rule as amended by the HITECH Act of 2009 establishes a national set of minimum security standards, including Administrative, Physical, and Technical Safeguards, to secure Protected Health Information (PHI) that an Applicant may create, receive, maintain, or transmit during a healthcare transaction. Applicant attests to having implemented the applicable Administrative, Physical, and Technical Safeguards of the HIPAA Security Rule, including notification procedures for breaches of unsecured PHI, in compliance with 45 CFR Part 164 Subparts C and D.	☐ Yes ☐ No ☐ NA
Applicants attests to completing state-required workers' compensation certification training.	☐ Yes ☐ No ☐ NA
Applicant attests that all registered motor vehicles have a required business name, USDOT Number, and MN DOT Certification Number. ***(Minnesota Medicaid Transportation Providers only)***	☐ Yes ☐ No ☐ NA
Applicant attests to maintaining an accurate record of motor vehicle identification information and vehicle safety inspections, tests, repairs, and maintenance, including dates and nature, as required by state and local law.	☐ Yes ☐ No ☐ NA
Applicant attests to having completed an online Ownership and Control Disclosure form as part of the Iowa Medicaid Universal Provider Enrollment Application process ***(Iowa Medicaid providers only)***.	☐ Yes ☐ No ☐ NA
Applicant attests to assume full responsibility for, and to indemnify and hold HOMELINK harmless from and against any and all claims, demands, causes of action, fines, fees, penalties, costs, expenses, losses, damages or liabilities of any type or nature whatsoever, including but not limited to reasonable attorneys' fees and expenses, arising from or in connection with any loss, personal injury or death resulting or arising from, directly or indirectly, the performance of covered services by Applicant, its employees and agents. Applicant shall not be responsible for any liability imposed by law upon HOMELINK, and HOMELINK shall not be responsible for any liability imposed by law upon Applicant. HOMELINK and Applicant each agrees to be responsible for its own liabilities to whatever degree determined.	☐ Yes ☐ No
Applicant attests to meeting all applicable requirements of the Occupational Safety and Health Administration's (OSHA) COVID-19 ETS (Emergency Temporary Standard) regarding occupational exposure.	☐ Yes ☐ No ☐ NA
Applicant attests to being a legal business entity (i.e., an LLC or Corporation), not an individual, organized and in good standing under applicable state law. A local business license is not sufficient. To maintain status as a provider in HOMELINK's network, HOMELINK may require that Applicant periodically provide proof that it remains active and in good standing under applicable state law.	☐ Yes ☐ No

Applicant Confidentiality/Non-Disclosure Statement

As a credentialed entity for HOMELINK®, Applicant understands that their employees and/or subcontractors will routinely handle and be in receipt of sensitive Protected Health Information (PHI) and/or financial data. Applicant agrees to hold said information about patients and their needs in confidence and not disclose any information without contacting HOMELINK to review privacy and security policies and procedures (HIPAA) surrounding the release of any PHI. Applicant understands that any medical records, medical information, PHI, and financial data is their responsibility and that the information contained within is the property of the patient and cannot be disclosed or otherwise used without patient consent, unless permitted by state and/or federal law.

By signing below, Applicant agrees to conform to the release of information policies and the confidentiality of the information about the patients with whom both parties are engaged in coordinating and/or providing services. Applicant understands that both federal and state laws apply to some parts of the release of information and any violation of HOMELINK's policies will be a violation of these laws.

Applicant accepts complete responsibility for the actions of their owners, officers, directors, employees, agents, and/or subcontractors and understands that violation of HOMELINK privacy and security policies may warrant immediate termination of the HOMELINK Transportation Provider Agreement between HOMELINK and Applicant and/or legal action.

Signature

By signing below, I certify that the information provided is complete and accurate to the best of my knowledge. I acknowledge that my eligibility for continued participation as a business entity is contingent upon the approval of the information provided within this application. I understand that my application may require review of information related to me on file with third-party entities, including but not limited to, state Medicaid and licensing boards, malpractice carriers, the Office of Inspector General's (OIG's) List of Excluded Individuals and Entities (LEIE), and the System for Award Management (SAM) administered by the US Government. I consent and authorize the release of such information.

I agree to notify HOMELINK in a timely manner, not to exceed sixty (60) days, of any changes in the information contained in this application.

Name of Company:_____(Print)

By:_____(Print)

Signature:_____ Date:_____

Title:_____ Phone:_____

The information requested in this application will be used in HOMELINK's credentialing process. All information will be treated as confidential information. Thank you for completing this credentialing application.

Applicant Documentation Requirements

Please provide the following documentation as required by the terms of your Transportation Provider Agreement.

To facilitate prompt processing of your credentialing application, please return only the forms and documents requested below. It is not necessary to provide us with booklets or binders as extraneous material may delay processing. If you need assistance completing this application, please contact the HOMELINK Credentialing Department at HomelinkCredentialing@vgm.com or call 866-575-8482.

Your completed application can be emailed to HomelinkCredentialing@vgm.com or faxed to 855-863-7189 or mailed to:

HOMELINK
ATTN: Credentialing Department
PO Box 1860
Waterloo, IA 50704

☐ Completed HOMELINK Transportation Credentialing Application
☐ Servicing Counties: Attach a list of all servicing counties by state; only a listing of specific counties will be accepted; do not submit maps and/or regional designations (e.g., southeast Iowa, etc.)
☐ Copy of signed W-9
☐ Copies of Medical Transportation Service Certificates (if applicable)
☐ Copies of Registrations and Approved Credentialing (if state required)
☐ Copies of state and/or business licenses (if applicable)
☐ Copies of Certificates of Insurance showing adequate coverages and limits as outlined in the Insurance Information section listing HOMELINK as an additional insured
☐ Copies of any Commercial General Liability, Professional Liability, and Commercial Business Auto insurance adverse actions for the past five (5) years, as applicable
☐ Copy of state-required workers' compensation certification training (if applicable)

Thank you for your prompt attention to this important request.