SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

ARKANSAS

REQUEST FOR QUALIFICATIONS – PROVIDER'S CREDENTIALS

CLASSIFICATION

1 **Application Type**		New		Anniversary		Renewal		Revision
2 **Mode of Transport:**		Ambulatory		Wheelchair		Stretcher		Bariatric Str

OWNERSHIP

3 **(Check One)**		**Individual**		**Partnership**		**Corporation**		**LLC**
		State Gov.		**County Gov.**		**Hosp. Auth.**		**Non-Profit**

4a Name of Owner(s):			4b Email Address:
5a Owner Street Address or P.O. Box:			5b Business Phone:
6a City:	6b State:	6c Zip Code:	6d Fax:

MANAGEMENT (If different from Owner)

7a Operations Manager:			7b Email Address:
8a Street Address or P.O. Box:			8b Business Phone:
9a City:	9b State:	9c Zip Code:	9d Fax:

BASIC QUALIFICATIONS

10a Has the owner or any party to this application had any certification or license revoked or had any other disciplinary actions levied from any state or federal agency? ***If yes, attach documentation explaining the circumstances.**	10b Yes/No?
11a Has the owner or any party to this application ever been convicted of a felony by this or any other state or federal court? ***If yes, attach documentation explaining the circumstances.**	11b Yes/No?
12a Is the owner, or any party to this application currently in any pending matter referred to in the preceding two items? ***If yes, attach documentation explaining the circumstances.**	12b Yes/No?

OPERATIONAL INFORMATION

13a Name of Service:		13b Number of Vehicles:
14 Doing Business As:		
15a Business Hours	15b After Hours Service(Circle One) Yes No	15c Long Distance Trips (Circle One) Yes No

16a Is the owner or any party to this application currently in a contractual or similar agreement with another agency for the provision of transportation of patients, members and/or clients? ***If yes, attach copy of contract/agreement.**	16b Yes/No?
17 Contractor/Contractee: (If additional space is needed, attach separate page)	

BUSINESS LOCATION (If Different from Owner's Address)

18a Business Location - Street Address:		18b County:
19a City:	19b State:	19c Zip Code:
20a Local Manager's Name:		20b Email Address:
21a Business Phone:	21b Emergency Phone:	21c Fax:

ADDITIONAL SATELLITE LOCATION(S) MUST BE RECORDED ON AN ADDITIONAL SHEET OF PAPER

SERVICE AREA INTEREST

22a Service County of Interest:
23a Service City/Area of Interest:
24a Service Facilities of Interest:

PAYMENT INFORMATION

25a Federal Tax Identification Number:	25b Email Address:
26a Payment Mailing Address: Street City State Zip	26b Circle One: Electronic Fund Transfer (EFT) or Paper Check by Mail

MANIFEST/TRIP REQUEST RECEIPT METHOD

27 Manifest Email Address:	
28 Manifest Fax Number:	
29 Web Portal Access (Circle One): Yes or No	30 Preferred Manifest Method:

CERTIFICATION

The undersigned certifies that the information contained in this application and all attached documentation is true and correct to the best of my knowledge and belief and that I will comply with Southeastrans, Inc. Rules and Policies, as amended, governing Independent Provider's contract. Provider shall operate as an independent Provider in providing services under this Contract, and not as an agent, representative or employee of Southeastrans.

32 Owner's Name:	
33a Owner's Signature: (Blue Ink Required)	33b Date:
34 Owner #2 Name (if applicable):	
35a Owner #2 Signature: (Blue Ink Required)	35b Date:

SERVICE AREA (Counties you will service):
