ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Transportation

I. Service Capacity

A. Check the transportation services you provide:

☐ Door to door taxi type service
☐ Van service
☐ Chair car
☐ Ambulance

B. List the number of vehicles owned or leased by type (e.g., sedan, van, chair car, etc.).

C. How many are more than 5 years old?

D. How many are used for back up?

E. Where are the vehicles garaged?

F. How do you ensure sufficient back up drivers?

G. What is your proposed rate for Transportation? Describe any additional charges.

H. Do you currently provide transportation services funded by the Executive Office of Health and Human Services?

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

I. If yes, list all such contracts. Include the contractor, contact, start date, and phone number.

J. When scheduling ride sharing (multiple consumers with different destinations) in a vehicle, what is the maximum additional travel time compared to direct routing?

K. Attach a copy of your inclement weather policy.

L. Describe maintenance/inspection procedures, including where it is done and by whom:
   1) Daily/Weekly

   2) Monthly/Quarterly

   3) Yearly

M. Are vehicles marked with business logo or name? Do employees wear uniforms and/or badge?

N. Describe your policy for assisting passengers in getting on/off vehicle.

O. Describe your policy for assisting passengers with parcels?

P. Describe minimum notice required for an authorized consumer to receive service including policy for exceptions and/or emergency requests.

Q. Describe your system for tracking and scheduling rides including use and recording of log sheets or trip sheets.

R. Describe your policy for handling medical emergencies

S. Describe your policy for transporting escorts required to assist consumer.

II. Qualifications

A. Has the company's vehicle insurance coverage ever been terminated by an action of an insurance company?

B. Has the company's personal liability insurance coverage ever been terminated by action of an insurance company?

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

C. Have there been any legal proceedings or claims against the company, alleging negligence or failure to observe transportation or motor vehicle rules that are open, pending, or closed within the past 10 years?

D. Describe the experience and qualifications of the person responsible for service provision (the manager of the program), if different from the information provided in the Administrative Overview.

E. Describe the experience and qualifications you require for drivers, dispatchers, and monitors (if applicable).

F. How do you ensure drivers have appropriate licenses that are current?

G. Describe policy/procedure and frequency for the following:

Alcohol and Drug Testing

Driving Record/History Check

H. Describe procedure and frequency for the following trainings, if applicable:

CPR

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

First Aid
Defensive Driving/Safe Driving
Sensitivity/Special Needs of Elders/Disabled
Other

III. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (drivers, monitors, dispatchers.).

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including documentation of trips.

Provider employee who completed this form

Name: _____ Date: _____

SERVICE SPECIFIC ON-SITE REVIEW

Transportation

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

Employee Records Review					
Provider Date Monitor					
Start Date & termination date, if applicable					
Number of reference checks					
CORI Check					
Orientation: Date					
Job Description(s)					
Ongoing training: Dates					
Supervision: Dates					
Driver's License (Class and Date of Expiration)					
If Applicable: DMV Registry Check/Driving History: CPR expires: First Aid expires: Health Record, including Alcohol/Drug testing:					
Annual Performance Appraisal: Date					
OIG monthly checks					
Comments					

SERVICE SPECIFIC ON-SITE REVIEW

Transportation

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

Consumer Records Review					
Provider Date Monitor					
ASAP Authorization					
ID Info- name; address; phone; DOB					
Emergency Contact (s) name and phone					
Physician(s) name and phone, if applicable					
Medical/ social diagnosis, if applicable					
Name of current CM					
Date of referral					
Service start date & termination date, if applicable					
Comments					
NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.					

Name and Position of Provider Direct Demonstrator	