

Medicaid Transportation Vendor Documentation

North Carolina _____ County Department of Social Services

Organization Information Organization Name as shown on income tax return _____ EIN _____
Doing Business As (DBA) information DBA Name _____ EIN _____ Former DBA Name(s) _____ EIN _____ Former DBA Name(s) _____ EIN _____ Years Doing Business under Current Name _____ Years Doing Business under Previous Name(s) _____
Business Address Primary Business Address _____ P.O. Box Address _____ Business Location 1 _____ Business Location 2 _____ (provide any additional business locations on a separate sheet)
Ownership Information How would you describe the ownership? (circle one) Sole Proprietor Partnership Single-Owner LLC Corporation City/Municipality Non-Profit For Corporation, Partnership, or Non-Profit: Please provide information for each person who has an ownership or control interest in the entity or in any subcontractor in which the entity has direct or indirect ownership or control interest of 5% or more.
Owner 1 Full Name (Last, first, Middle) _____ SSN or EIN _____ Address (street) _____ (city) _____ (state) _____ (zip) _____ Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____ Familial Relationship to other owners (Spouse, Mother, Father, Sister, Brother, None, etc.) _____
Owner 2 Full Name (Last, first, Middle) _____ SSN or EIN _____ Address (street) _____ (city) _____ (state) _____ (zip) _____ Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____ Familial Relationship to other owners (Spouse, Mother, Father, Sister, Brother, Child, None, etc.) _____
Owner 3 Full Name (Last, first, Middle) _____ SSN or EIN _____ Address (street) _____ (city) _____ (state) _____ (zip) _____ Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____ Familial Relationship to other owners (Spouse, Mother, Father, Sister, Brother, None, etc.) _____ (provide any additional ownership information on a separate sheet)
Ownership or Controlling Interest in Other NEMT Vendors Provide the name of any other NEMT vendor in which a person listed above also has an ownership or control interest. _____
Managing Relationships Disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator) and Electronic Funds Transfer (EFT) authorized individual. Relationship 1 Full Name (Last, first, Middle) _____ Social Security Number _____ Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____ Familial Relationship to NEMT Vendor (Spouse, Mother, Father, Sister, Brother, Child, None, etc.) _____

Relationship 2

Full Name (Last, first, Middle) _____ Social Security Number _____

Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____

Familial Relationship to NEMT Vendor (Spouse, Mother, Father, Sister, Brother, Child, None, etc.) _____

Relationship 3

Full Name (Last, first, Middle) _____ Social Security Number _____

Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____

Familial Relationship to NEMT Vendor (Mother, Father, Sister, Brother, None, etc.) _____

Relationship 4

Full Name (Last, first, Middle) _____ Social Security Number _____

Date of Birth (MM/DD/CCYY) _____ Business Relationship to NEMT Vendor _____

Familial Relationship to NEMT Vendor (Mother, Father, Sister, Brother, None, etc.) _____

Health Care Related Criminal Convictions

Provide names of each individual who has an ownership or controlling interest in the vendor who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

Person 1: _____ Person 2: _____

By my signature, I attest that no one affiliated or employed with _____ has ever been convicted of:

- Medicare/Medicaid or any other healthcare program fraud;
- Neglect or abuse of a patient
- Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Interference or obstruction of an investigation into any of the above criminal offenses.

Name _____ Signature _____

Date _____

For County Use<http://oig.hhs.gov/exclusions/index.asp>**Results of OIG Federal Inquiry:**

Circle One: No Match Found Organization or Business Owner Manager

Name of individual/entity which resulted in an exclusion match _____

Exclusion Code _____

Transportation Coordinator/Designee Signature _____

Date _____

<https://vendortracking.dhhs.state.nc.us/default.aspx>**Results of NC DHHS Vendor Penalty Tracking Database**

Circle One: No Match Found SSN Owner

Name of owner and/or SSN of owner which resulted in an exclusion match _____

Exclusion Reason (Action Issued) _____

Transportation Coordinator/Designee Signature _____

Date _____