**PUBLIC AUTO SUPPLEMENTAL APPLICATION—NON-EMERGENCY TRANSPORT**

**(Complete in Addition to the Commercial Automobile Application)**

**PROVIDE COPIES OF DRIVER TRAINING MANUAL AND SAFETY PROCEDURES**

**Applicant’s Name:**

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| --- |
| **1. Description of operations:**       |

Number of years in business:       Number of years under current management:

**2. Is your service a subsidiary or division of another company?** [ ]  Yes [ ]  No

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| --- |
| If yes, advise the name of the company, their address and their relationship to you:       |

**3. Has this service ever operated under another name?** [ ]  Yes [ ]  No

If yes, what name?

**4.** [ ]  Profit [ ]  Nonprofit Source of funding:

**5. Do you have a contract with a social service agency?** [ ]  Yes [ ]  No

If yes, list agencies:

**6. Percentage of fares paid by:**

Medicaid/Medicare:     % VA Benefits:     % Other Government Benefit:     % Passengers:     %

Other:     % If Other; Explain:

**7. Number of trips per year:**

Number of Emergencies:       Number of Non-Emergencies:

Percentage of Wheelchair Transport:      %

Percentage of Stretcher Transport:      %

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| **8. a. List major cities entered:**       |

**b. What percentage of the operations involves transportation in these cities?**      %

**9. Is any transportation provided to the following destinations?** [ ]  Yes [ ]  No

If yes, indicate percentage of all applicable and advise of any other destination:

Shopping Districts:     % Workplaces:     % Senior Centers:     % Schools:     %

Daycare Centers:     % Psychiatric Centers:     % Heliport or Airport:     % Other:     %

**10. Are passengers assisted in or out of the autos?** [ ]  Yes [ ]  No

If yes, provide percentage of: Curb-to-Curb:     % Door-to-Door:     % Door Through Door:     %

**11. Who dispatches your calls?** [ ]  911 [ ]  Outside Sources [ ]  In-house by your own employees or volunteers

**12. Do you distribute any medical supplies or equipment?** [ ]  Yes [ ]  No

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| If yes, provide details:       |

**13. Indicate level of training and number of individuals who drive and/or provide client care** (full-time, part-time or volunteer):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **EMT Basic** | **EMT Advanced** | **EMT Paramedic** | **Other** | **No Certification** |
| **Number of Employees** |       |       |       |       |       |
| **Number of Volunteers** |       |       |       |       |       |

If “other” is marked above, explain:

**14. Identify the types of special driver training programs that your drivers receive:**

[ ]  General Driver Orientation [ ]  Defensive Driving [ ]  Primary First Aid

[ ]  Advanced First Aid [ ]  CPR [ ]  Passenger Assistance Training

[ ]  Human Relations Skills [ ]  Non-Medical Emergency Training [ ]  Emergency Vehicle Evacuation

[ ]  Emergency Vehicle Operators Course (EVOC)

**15. Do you:**

Screen employees and drivers’ histories for sexual abuse charges and convictions? [ ]  Yes [ ]  No

Verify licenses/professional certificates? [ ]  Yes [ ]  No

Screen employees for previous involvement as defendants in malpractice litigation? [ ]  Yes [ ]  No

**16. Number of units equipped with lights and sirens?**

**17. How many vehicles are equipped with the following wheelchair tie-down mechanism?**

3 Point Tie-Down:       4 Point Tie-Down:

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| **18. Describe wheelchair and stretcher tie-down procedures:**       |

**19. Is scooter transport (electric scooters or mobility scooters) provided?** [ ]  Yes [ ]  No

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| If yes, how are passengers secured?       |

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| If yes, how are scooters secured within the vehicle?       |

**20. Are any vehicles not equipped with both lap belts and shoulder harnesses for the passengers?** [ ]  Yes [ ]  No

**21. Is there an accident review procedure?** [ ]  Yes [ ]  No

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| If yes, describe:       |

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| **22. Describe vehicle maintenance program:**       |

**23. Does Applicant carry Professional Liability coverage?** [ ]  Yes [ ]  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Number** | **Carrier** | **Limits** | **Term** | **Is Loading and Unloading Included** |
|       |       | $      |       |       |

**24. Does Applicant carry General Liability coverage?** [ ]  Yes [ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Policy Number** | **Carrier** | **Limits** | **Term** |
|       |       | $      |       |

**25. Are all vehicles owned by you?** [ ]  Yes [ ]  No

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| --- |
| If no, explain:       |

Are they leased, etc.? [ ]  Yes [ ]  No

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| --- |
| Give details:       |

**26. Do employees use their own vehicles in your business?** [ ]  Yes [ ]  No

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| --- |
| Explain:       |

Are any employees/volunteers’ vehicles used for client transport? [ ]  Yes [ ]  No

**27. Are all drivers covered by Worker’s Compensation?** [ ]  Yes [ ]  No

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| --- |
| If yes, provide carrier name:       |

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| **28. Any other pertinent information about your business:**       |

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON):** Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON):** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

APPLICANT’S NAME AND TITLE:

APPLICANT’S SIGNATURE: DATE:

(Must be signed by an active owner, partner, or executive officer)

PRODUCER’S SIGNATURE: DATE: