Medical Transportation Program Provider Application

A STATE MEDICAID CONTRACTOR

REV. XIII

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Introduction

Dear Applicant:

Thank you for your interest in becoming a Medical Transportation Provider. Your participation in the Medical Transportation Program (MTP) is vital to the successful delivery of Texas Medicaid services, and we welcome your application for enrollment.

This application must be completed in its entirety as outlined in the instructions below and will be reviewed by the Texas Health and Human Services Commission (HHSC) and the Texas Medicaid & Healthcare Partnership (TMHP).

Providers are encouraged to review the current *Texas Medicaid Provider Procedures Manual* for information about provider responsibilities, benefits and limitations, and much more. The provider manual is updated monthly, and the current and archived provider manuals can be accessed on the TMHP web site at **www.tmhp.com**. Select "Medicaid Provider Manual" from the Providers page.

There is no guarantee your application will be approved for processing.

Privacy Statement

With a few exceptions, Texas privacy laws and the Public Information Act entitle you to ask about the information collected on this form, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the Texas Administrative Code, 1 TAC §351.17-§351.23.

For questions concerning this notice or to request information or corrections, please contact Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **1-800-925-9126**. TMHP customer service representatives are available Monday through Friday from 7 a.m. to 7 p.m., Central Standard Time.

Affordable Care Act (ACA) Requirements

In compliance with the Affordable Care Act of 2010 (ACA), all providers are subject to ACA screening procedures for newly enrolling and re-enrolling providers. All providers must be screened upon submission of an application, including, but not limited to:

- Applications for providers that are new to Texas Medicaid
- Applications for providers that are requesting new practice locations
- Applications for currently-enrolled providers that must periodically revalidate their enrollment in Texas Medicaid.

Refer to: Code of Federal Regulations (CFR) Title 42 Ch. IV, Part 455, Subpart E-Provider Screening and Enrollment; and Texas Administrative Code (TAC) Title 1, Part 15, Chapter 352, for the statutory provisions for these requirements.

Provider Screening

All providers are categorized by the CMS-defined risk levels of limited, moderate, and high based on an assessment of potential for fraud, waste, and abuse for each provider type. Providers will be screened according to their risk level and are subject to various screening activities for each risk level. Risk level assignments may be increased at any time at the discretion of HHSC. In these instances, the provider will be notified by HHSC, and the new risk level will apply to enrollment-related transactions.

Provider Revalidation

In compliance with ACA, TMHP is required to revalidate the enrollment of all providers at least every three to five years depending on provider type. Providers will receive notification that they are required to revalidate before their revalidation deadline. The ACA screening criteria applies during revalidation. Providers that do not revalidate their enrollment by the designated date will be disenrolled.

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested in the Contact Information section of this application.

Contact Information

For information about Medicaid provider identifier requirements or the status of your enrollment, call the TMHP Contact Center toll-free at **1-800-925-9126**.

Thank you for applying to become an Medical Transportation Provider.

Application Instructions

Required Forms for Medical Transportation Provider Enrollment

To avoid any delay of the enrollment process, use this sheet as a checklist. For assistance with completing these forms, call the TMHP Contact Center at **1-800-925-9126**.

Important: *To complete the Medical Transportation Provider enrollment application process, the following forms must be completed and mailed to TMHP for processing. Please return only the pages necessary for proper processing. Do not include any pages marked as "Do Not Return" in the upper right corner of this application.*

- ☐ A copy of the completed Applicant Contact Information page
- ☐ A completed Application Payment Form (see the instructions below for additional information)
- ☐ A completed Medical Transportation Provider Enrollment Application (page 8)
- ☐ A completed MTP Principal Information Form (MTP-PIF)
- ☐ A completed Disclosure of Ownership and Control Interest Statement Form
- ☐ A signed Medical Transportation Provider Agreement. (Original signatures required; see instructions below for additional information.)

If the enrolling provider is **incorporated**, the following additional forms must be completed and returned for processing:

- ☐ Corporate Board of Directors Resolution Form – MUST BE NOTARIZED. (original signatures required)
- ☐ For corporations formed prior to January 1, 2006: Articles or Certificate of Incorporation/Certificate of Authority/ Certificate of Fact *(required for in-state corporations; certificate can be obtained from the Office of Secretary of State)*
- ☐ For corporations formed on or after January 1, 2006: Certificates of Formation or Certificate of Filing
- ☐ Franchise Tax Account Status Page (Refer to the instructions table for additional information.)

Important: *Retain a copy for your records of all documents submitted for enrollment.*

Completing the Application and Other Forms

Complete this enrollment application using the following information:

Item	Instructions
Application Payment Form	An application fee is required for enrollment. This application cannot be processed if the fee is not submitted with the application. *Approval of your application does not guarantee affiliation or participation as a Demand Response Transportation Services Provider with a Managed Care Organization or its subcontractor or HHSC.* ***Enrollment fees will not be refunded once the application process has begun.***
Requesting Enrollment as:	**Facility enrollment.** Medical Transportation Providers are enrolled as facility providers. This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity.

Item	Instructions
Type of Enrollment	Select your provider type from the following options: **Demand Response Transportation Services Provider:** A profit or non-profit entity, including Transportation Network Companies (TNCs), enrolled through the Texas Medicaid & Healthcare Partnership (TMHP) for participation status as a Medical Transportation DRTS Provider. **Transportation Network Companies (TNC):** A ride sharing entity such as Uber and Lyft that uses mobile applications to enable people to secure individual and carpooling rides from drivers who use their own vehicles.
Section A – Provider of Service Information	This section is for provider demographic information. Provide complete and correct information as required. To apply for a National Provider Identifier (NPI), applicants should go to **https://nppes.cms.hhs.gov/NPPES/Welcome.do**
MTP Principal Information Forms (MTP-PIF1 and MTP-PIF2)	A separate copy of the MTP Principal Information Forms must be completed in full for each Principal (Entity [PIF1] or Principal [PIF2]) prior to enrollment.
Disclosure of Ownership and Control Interest Statement	Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.
Medical Transportation Provider Agreement	Complete the required information at the beginning of the form, read the agreement information, and sign and date the agreement to indicate that you have read and agree with the terms of enrollment as required by the Texas HHSC.

Instructions for the additional attachments available in Appendix A:

Item	Instructions
Corporate Board of Directors Resolution	This form is required if the applicant is incorporated. This form must be notarized, and an original signature is required. This form **cannot** be faxed to TMHP.
The following forms must be obtained from other sources and submitted with this application as appropriate for the requested provider type:	
Franchise Tax Status Page	This certificate must be obtained from the Texas State Comptroller's Office website at **http://www.window.state.tx.us/taxinfo/coasintr.html.** This request is free. Applicants who answer "yes" to the question "Do you have a 501(c) (3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status Page from the State Comptroller's Office.

Applicant Contact Information

Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address on this application.

Contact Name: *Last*	*First*	*Middle Initial*

Contact Telephone Number:	**Contact Fax** *(if applicable)*:

Email Address *(if applicable)*:

Address: *Number*	*Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Application Payment Form

In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications received in response to re-enrollment

Instructions: Complete Section A or Section B but not both. If you are using a Medicare certification number for this enrollment, complete section A. If you are not using a Medicare certification number for this enrollment, complete Section B:

Section A. I am Using a Medicare Number for This Enrollment

Instructions: *If you are using a Medicare certification number for this enrollment, complete Section A by selecting ONE of the following statements*:

☐ I completed the Medicare enrollment process on or after March 25, 2011, and have paid the application fee to Medicare, or have received a hardship waiver from Medicare. I am including with this application proof from Medicare that the application fee payment was made, or proof that my application fee hardship waiver was approved.

☐ I have not completed the Medicare enrollment process, or I completed the Medicare enrollment process on or before March 24, 2011, and have not paid an application fee to Medicare.

NOTE: *If you have not completed the Medicare enrollment process, or if you completed the Medicare enrollment process on or before March 24, 2011, and have not paid an application fee to Medicare, complete the Medicare enrollment process and submit your Texas Medicaid enrollment application with proof that the application fee payment was made to Medicare or proof that an application fee hardship waiver was approved.*

Section B. I am Not Using a Medicare Number for This Enrollment

Instructions: *If you are not using a Medicare certification number for this enrollment, complete Section B by selecting ONE of the following:*

☐ I am submitting the application fee to Texas Medicaid by paper check, money order, or cashier's check with this application.

Note: *Providers must include a check, money order, or cashier's check with their Texas Medicaid provider enrollment packet submission for the application fee. Cash cannot be accepted. Make the check payable in the amount of $599.00 to Texas Medicaid & Healthcare Partnership (TMHP).*

☐ I attest that I have already paid the application fee to another state's Medicaid program or CHIP program and have been approved for enrollment in another state's Medicaid program or CHIP program. My proof of payment and enrollment is attached to this application. I understand that if my proof of payment to another state's Medicaid program or CHIP program is found to be unacceptable for any reason, I may be required to pay an application fee towards my Texas Medicaid enrollment application.

☐ I am requesting an application fee waiver due to financial hardship. My documentation that supports my request is attached to this application. I understand that I must submit a letter (and supporting documentation) with my enrollment application that details the reason(s) I am unable to pay an application fee. I understand that if the waiver request is denied, I will be required to submit an application fee if I wish to proceed with the Texas Medicaid enrollment process.

Note: *If hardship waiver was issued by another state, you must also request a waiver from Texas Medicaid.*

Medical Transportation Provider Enrollment Application

- **All information must be completed and contain a valid signature to be processed. If a question or answer does not apply, enter "N/A".**
- **Original signatures only; copies or stamped signatures not accepted.**
- **Use blue or black ink.**

TYPE OF ENROLLMENT *(select one)*:

☐ New enrollment (new provider, practice, location, etc.)
☐ Re-enrollment

REQUESTING ENROLLMENT AS:

☒ Facility

TYPE OF ENROLLMENT *(select one)*:

☐ Demand Response Transportation Services (DRTS) Provider
☐ DRTS Provider - Transportaion Network Company

Section A: Provider of Service Information

Existing Texas Provider Identifiers (TPIs):
National Provider Identifier (NPI): *(Applications cannot be processed without an NPI or API, regardless of the state in which a provider's practice is located. NPI must be an Organizational NPI via National Plan & Provider Enumeration System [NPPES]. For more information, see the Provider Enrollment Chapter in the current Texas Medicaid Provider Procedures Manual.)*

Group/Facility Name: *(Legal entity name.)*	
Business e-mail: *(if applicable)*	**Website address:** *(if applicable)*
Telephone number:	
Physical address: You must give a street address. PO boxes will not be accepted. Number Street Suite City State ZIP	
Mailing address: *(optional)* Number Street Suite City State ZIP	
Physical address FAX number:	**Mailing address FAX number:** *(optional)*
Doing Business As (DBA):	
Employer Identification Number:	

Instructions for Completing the Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS
Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS
These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of

(*continued on next page*)

(*continued from previous page*)

the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Note: *All individuals listed in Section III(a) must submit a PIF-2.*

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is "Yes," list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is "Yes," identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is "Yes," list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship

Please disclose any of familial relationships between principals and/or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

Disclosure of Ownership

This form is required for all individuals, groups, and facilities (excluding performing providers and SHARS providers).

I.	**Identifying information**		
(a)	**Legal Name** (*according to the IRS*)**:**	**DBA:**	**Telephone Number:**
	Physical/Corporate Address: Number Street Suite City State ZIP		

II.	**Answer the following questions by checking Yes or No.** *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?	☐ Yes ☐ No
(b)	Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months? *(Medicare providers only)*	☐ Yes ☐ No

III. Type of Entity (*Select only one; must match entity on W9)***:**

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Limited liability company (*Enter the tax classification [C=C corporation, S=S corporation, P=partnership*]): _____

☐ Trust/estate ☐ Other *(specify)* _____ _____

Do you have a 501(c)(3) Internal Revenue Exemption? ☐ Yes ☐ No

Providers who answer "yes" to the question "Do you have a 501©(3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status from the State Comptroller's Office.

(a) **List the names of any other person or entity with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*

	Name:	**Address:**	**Federal Tax ID:**
1.			
2.			
3.			

(b)	**Do you currently have a creditor with a security interest in a debt that is owed by you?** **Is the creditor(s) security interest protected by at least 5 percent of your property?**	☐ Yes ☐ No ☐ Yes ☐ No

List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property. *All listed creditors must also complete a Principal Information Form (PIF-2).*

Last Name/Company Name:	First Name:	Percent of Security Interest:

(c) **If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.** ***Note:*** *Each director identified in this section must also complete a PIF-2. All PIF-2 documents must be submitted with this application. Attach additional pages if needed.*

Remarks:

Section B: Owners, Partners, Officers, Directors, and Principals

Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals (as defined in the Principal Information Form [PIF-2]) of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent unless otherwise noted in the instructions. If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect. (*Add additional pages if necessary.*)

1.	**Name:**		**Percentage Owned:**	
2.	**Name:**		**Percentage Owned:**	
3.	**Name:**		**Percentage Owned:**	

IV.	Ownership	
(a)	**Has there been a change in ownership or control within the last year?**	☐ Yes ☐ No
	If "Yes," give date:	
(b)	**Are you seeking enrollment due to change of ownership?**	☐ Yes ☐ No
(c)	**Do you anticipate any change of ownership or control within the year?**	☐ Yes ☐ No
	If "Yes," give date:	
(d)	**Do you anticipate filing for bankruptcy within the year?** (*see provider agreement for additional information)*	☐ Yes ☐ No
	If "Yes," give date:	
(e)	**Are any of the new owners related to any of the former owners?**	☐ Yes ☐ No

(f)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If "Yes," please list the name of the former owners below.*		☐ Yes ☐ No
	Last Name:	**First Name:**	**Middle Initial:**

V.	**Management**	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If "Yes," give date of change in operations:	

VI.	**Staffing**	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	**Affiliation**	
(a)	**Is the provider identified in Section I. above chain affiliated?**	☐ Yes ☐ No
	If "Yes," provide the name, address, and Federal Tax ID number of the chain's corporate/home office: Name Address Federal Tax ID	

VIII.	**Capacity**	
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*	☐ Yes ☐ No
	If "Yes," give: Year of change: Current Beds: Prior Beds:	

IX.	**Disclosure of Relationship**		
(a)	**Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):**		
	Provider/Principal 1:	**Has a Relationship as:**	**To Provider/Principal Name 2:**

PLEASE NOTE: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form, original signature and notarized.
- Certificate of Formation, Certificate of Filing, Certificate of Authority, or Certificate of Registration.
- Franchise Tax Account Status, available at **https://mycpa.cpa.state.tx.us/coa/Index.html**.

MTP Principal Information Form (MTP-PIF1) For Entities

Required for the entity enrolling.

Tax ID number as shown on the W9 IRS form:	**Legal name as shown on the W9 IRS form:**
Company Name:	
Address as shown on the W9 IRS form: Number Street Suite City State ZIP	
How is the entity organized to conduct business activities? *Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental*	
Do you conduct business under an assumed name? *If **Yes**, provide the assumed name below.*	☐ **Yes** ☐ **No**
Assumed Name:	

The following information must be completed by all Principals. For additional names or addresses, attach pages as necessary.

Physical address:					
Number	Street	Suite	City	State	ZIP
Mailing address (*if different from address above*)**:**					
Number	Street	Suite	City	State	ZIP
Federal Tax ID number:					

Previous Physical address (*optional*)**:**					
Number	Street	Suite	City	State	ZIP
Previous Mailing address (*optional*)**:**					
Number	Street	Suite	City	State	ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*
Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, or Unknown: (attach additional sheets if necessary)*

Effective date of your role in the provider organization: MM/DD/YYYY	**Do you have a relationship with a separate provider?**
	☐ Yes ☐ No

List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

All fields in this section must be completed in full.

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.	
Have you ever been sanctioned (as defined above) in any state or federal program?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*	
Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	☐ Yes ☐ No
If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*	
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No
If ***Yes*** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency. (attach additional sheets if necessary)*	
"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged or is there an outstanding warrant for arrest?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	

All fields in this section must be completed in full.

Are you currently subject to court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *please provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

MTP Principal Information Form (MTP-PIF2) For Principals

Required for any person that meets the definition of a "Principal" as defined below. Each entity is required to complete MTP-PIF1.

A separate copy of this MTP Principal Information Form (MTP-PIF2) must be completed in full for each Principal of the Provider before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the Provider Agreement.

Last Name:	**First Name/Middle Initial:**
Maiden Name (*optional*)**:**	**List any other alias, name, or form of your name ever used (*optional*):**

The following information must be completed by all Principals. For additional names or addresses, attach pages as necessary.

Physical address: Number Street Suite City State ZIP
Mailing address (*if different from address above*)**:** Number Street Suite City State ZIP
Social Security Number:

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*
Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official, Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, or Unknown: (attach additional sheets if necessary)*

Effective date of your role in the provider organization: MM/DD/YYYY	**Do you have a relationship with a separate provider?**
	☐ Yes ☐ No

List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

All fields in this section must be completed in full.

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.	
Have you ever been sanctioned (as defined above) in any state or federal program?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*	
Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	☐ Yes ☐ No
If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*	
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No
If ***Yes*** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency. (attach additional sheets if necessary)*	
"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged or is there an outstanding warrant for arrest?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	

All fields in this section must be completed in full.

Are you currently subject to court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *please provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Medical Transportation Provider Agreement

Medical Transportation Provider services are authorized under federal and state law. Services for Medicaid were established under 42 United States Code §1396a; 42 Code of Federal Regulations §§431.51 and 440.170(a). Program rules are found under Texas Administrative Code (TAC), Title 1 Part 15 Chapter 380 for MTP and Transportation for Indigent Cancer Patients and Title 25 Part 1 Chapter 38 for Children with Special Health Care Needs (CSHCN) Services Program.

Terms and Conditions

1. Any attempt by the facility to bill or recover money from clients beyond the conditions stated in this agreement is in noncompliance with these rules and constitutes a violation of the agreement between HHSC and the facility for participation in MTP.
2. Warrants may be held by the State Comptroller when there is a tax liability and/or restitutions due on payments to the facility. It will be the responsibility of the facility to resolve these issues with the Comptroller of Public Accounts (CPA).

By signing below, the facility agrees to furnish any and all disclosures regarding business transactions requested by HHSC or HHS in accordance with 42 CFR §455.105.

Term of the Agreement

I certify that the information listed in this enrollment application is accurate and valid through the current State Fiscal Year. I understand that failure to honor state-established rates, policies, and procedures, including all services offered; submission of inaccurate information; or deficiencies in service levels, could result in cancellation of this enrollment by HHSC/MTP.

Provider must notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy and must copy TMHP and HHSC with all the Provider's pleading in the case. A failure to notify TMHP and HHSC of a bankruptcy petition is a material breach of the Provider Agreement.

Provider must notify TMHP if the Provider is subject to a Change of Ownership (CHOW) question, along with a new Medical Transportation Provider Application. The forms can be located at www.tmhp.com. Select the MTP tab.

Provider agrees to inform HHSC or its designee, in writing and within 30 calendar days, of any changes to the information submitted in connection with its application to participate in the Medicaid program, whether such change to the information occurs before or after enrollment.

Privacy, Security, and Breach Notification

"Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

(a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);

(b) Sensitive Personal Information as defined in Texas Business and Commerce Code section 521.002);

(c) Federal Tax Information (as defined in IRS Publication 1075);

(d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);

(e) Social Security Administration data;

(f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

Any Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation the following:

(a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(f) OMB Memorandum M-07-16;

(g) Texas Business and Commerce Code Chapter 521;

(h) Texas Health and Safety Code, Chapters 181 and 611;

(i) Texas Government Code, Chapter 552, a applicable; and

(j) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

Provider will ensure that any subcontractor of Provider who has access to HHSC Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider and Provider will submit a copy of that Business Associate Agreement to HHSC upon request.

Note: *A failure to certify or a false statement on any of these will disqualify the facility from being listed as an MTP-eligible facility. All signatures must be original; stamped signatures not accepted.*

Name of Facility:	
Signature of Authorized Representative:	**Date of Signature:**
Authorized Representative: Printed	**Representative Title:**
Telephone Number:	**E-mail Address:**

Appendix A: Additional Forms

The following additional forms must be completed and returned with the application, if applicable:

- Corporate Board of Directions Resolution

Corporate Board of Directors Resolution

THE FOLLOWING FORM IS FOR CORPORATIONS ONLY,
AS INDICATED ON THE DISCLOSURE OF OWNERSHIP, QUESTION III (B).

State Of _____

County Of _____

On The _____ Day Of _____, 20_____, at a meeting of The Board Of Directors Of _____, A Corporation, held in the city of _____ _____, in_____ county.

With A Quorum Of The Directors Present, The Following Business Was Conducted:

It was duly moved and seconded that the following resolution be adopted:
Be it resolved that the board of directors of the above corporation do hereby authorize

_____

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Texas Health and Human Services Commission, and to execute said contract or contracts on behalf of the corporation, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the by–laws and Articles of Incorporation.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the board of directors of

_____,

held on the _____ day of _____, 20_____.

_____
Signature of Secretary

Subscribed and Sworn Before Me, _____, a Notary Public for the County of _____, on the _____ day of _____, 20____.

Notary Stamp/Seal

Notary Public, County of _____

State of _____

Signature _____

MESSAGE TO NOTARY:

COMPLETE ALL OF THE BLANKS IN THIS NOTARY STATEMENT.

Appendix B: TMHP Contact Information

Written Communication

Enrollment Applications:

Texas Medicaid & Healthcare Partnership
Attn.: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Telephone Communication

Note: *Please have your NPI/API readily available to expedite your call.*

TMHP Contact Center **1-800-925-9126**
TMHP EDI Help Desk **1-888-863-3638**