



HOMELINK Transportation Agreement

PO Box 1860 · Waterloo, IA 50704
Main Phone 800-482-1993 · Credentialing Phone 866-575-8482 · Fax 855-863-7189

To: Provider

Fax: Fax

Attn: Dear Provider

Date: 08/31/2017

From: HOMELINK Credentialing Team

Pages: Page 1 of 11

Re: HOMELINK Transportation Agreement

Dear Provider:

HOMELINK® is a National Provider Network that currently has contracts with multiple insurance companies and other payer sources to provide in-network services to their clients.

HOMELINK contracts with a wide variety of insurance companies to arrange for the medically needed products and services. Providing superior quality service to these patients is a cornerstone of our business.

The enclosed HOMELINK Transportation Agreement contains the terms and process requirements to become part of our Network.

Please review each section prior to signing this agreement and contact our Credentialing/Certification Team by phone at **866-575-8482** or Email: HomelinkCredentialing@vgm.com if you have any questions. We also have a website page to obtain a copy of the certification application at www.HomelinkCredentialing.com.

Thank you for your prompt attention to this matter; your cooperation is greatly appreciated. **Please respond with your completed information within 15 business days of receipt.** Your completed agreement requirements can be faxed to 855-863-7189 or mailed to:

HOMELINK ATTN:
CREDENTIALING/CERTIFICATION TEAM
PO BOX 1860
WATERLOO, IA 50704

Sincerely,

Dave Kazynski - HOMELINK President

Teri Smith - Credentialing/Certification Officer

The following document is not a contract

Notice of Confidentiality: The document accompanying this electronic transmission contains confidential information belonging to the sender, which is legally and/or medically privileged. The information is intended only for the use of the individual or entity named above. If you are the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of the contents of the information is strictly prohibited. If you have received this electronic transmission in error, please immediately notify us by telephone to arrange a return of the document to us.



HOMELINK® Network Transportation Provider Agreement

This agreement is entered into by and between VGM Group Inc. dba HOMELINK (hereinafter called “HOMELINK”) and (hereinafter called “Provider”):

THAT WHEREAS, HOMELINK is engaged in the business of delivery of healthcare services at the request of various Insurers, Health Maintenance Organizations, Employers and other Third Party Payers; and

WHEREAS the Provider, being duly registered and appropriately licensed as required in the State(s) in which it provides services, agrees to provide, furnish and supply transportation to patients referred to it and as authorized by HOMELINK upon the following terms and conditions:

I. Engagement of Services

The Provider shall provide services to patients in the areas that it serves as referred and authorized by HOMELINK. Provider, at its sole discretion, has the option to accept or reject any referral from HOMELINK, but upon acceptance agrees that services will include the provision of transportation services and same shall be provided only as ordered and as authorized by HOMELINK pursuant to this agreement.

II. Billing and Reimbursement

HOMELINK shall pay Provider for services according to the condition and terms described in Exhibit B. In no event shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against patients or any persons other than HOMELINK or any applicable third party payer for services provided pursuant to this Agreement.

III. Insurance

The Provider shall provide written evidence of bodily injury, property damage liability, and auto insurance in the amount of at least \$1,000,000 or state requirements and shall maintain said coverage throughout the term of the contract.

Provider agrees to defend and hold HOMELINK harmless from any and all liability arising from any acts or omissions of the Provider including claims and suits in which it is claimed that a party indemnified hereunder is also or partially at fault. Provider will provide required insurance verification within thirty (30) days of the date of contract execution, but, in any event, prior to rendering any services. Provider will have HOMELINK listed as an additional insured for both Auto & General Liability policies.



IV. Non-Discrimination

The validity of this Agreement and any of its terms and provisions is bound by non-discrimination in hiring practices outlined in regulations and relevant orders of the Secretary of Labor.

V. Relationship Between Parties

None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the parties, or any of their employees shall be construed to be the agent, employer or representative of the other. A failure of HOMELINK to perform under this agreement shall not relieve Provider of its obligations to patients.

VI. Entire Agreement

This instrument contains the entire Agreement of the parties hereto and supersedes all prior oral or written agreements or understanding between them with respect to the matters provided for herein. This Agreement may not be amended, modified or assigned except by written agreement duly executed by each party to this Agreement.

VII. Termination

This Agreement shall continue until terminated upon ninety (90) days written notice by any party to each of the others at the address set forth in the Notice paragraph, sent certified or registered mail, return receipt requested. In the event any party fails to comply with any provision of the Agreement, the party in violation must be given written notice of their failure to comply and ten (10) business days from receipt of notice within which to rectify the non-compliance. If the non-compliance is not rectified within the allotted ten (10) days, notice may be given to the non-complying party that the Agreement will be terminated.

VIII. Notice

*Any notice regarding this Agreement shall be in writing and sent certified or registered mail to Provider at **Provider**, Address, City, State Zip and to **HOMELINK**, Attn: Credentialing/Certification Team, PO Box 1860, Waterloo, Iowa 50704.*



IX. Attestation To Correctness and Completeness

I agree to notify Homelink immediately in writing should events occur during the course of participation that would change any information on this application.

I understand that my continued participation with Homelink is contingent upon my acceptance to the Network and my continuing to positively maintain appropriate certifications.

I attest that all information, including, supporting documentation, submitted by me in connection with this application is true and complete to the best of my knowledge and belief. I agree to update this application while it is being processed, should there be any change in the information provided that could affect the application or its outcome.

X. Confidentiality and Non-Disclosure Statement

This Agreement and the terms and conditions herein shall be treated by the parties as strictly confidential. Accordingly, the parties agree not to directly or indirectly disclose this Agreement or the terms and conditions herein, including but not limited to, all schedules and financial terms to any third party. The parties agree that the breach or prospective breach of this provision will cause irreparable harm for which money damages may not be adequate. The parties therefore agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof. This provision shall not apply to disclosures required by law, provided such disclosure is limited to the extent required by law. This paragraph will survive termination of this Agreement.

Name of Company: _____ **(Print)**

By: _____ **(Print)**

Signature: _____ **Date:** _____

Title: _____ **Phone:** _____

The information requested will be used in HOMELINK's credentialing/certification process. All information will be treated as confidential information. Thank you for completing this credentialing application.



HOMELINK

HOMELINK® Transportation Provider Agreement Application

I. Primary Company Information

Please select type of ownership:

Sole Owner Corporation Not for Profit Other: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Fax: _____

Web Referral Email Address: _____

Do you have access to the Internet? Yes No

Website: _____

Is your company minority owned? Yes No

Is your company owned by a woman? Yes No

Are you required to have a State License or Certification to provide service? Yes No

****Attach a copy of State Business License, if applicable**

Are you required to have Medical Transportation Service Certificates? Yes No

****Attach a copy of Medical Transportation Service Certificates, if applicable**

II. Hours of Operation

Weekdays	Hours of Operation	Weekend	Hours of Operation
Monday		Saturday	
Tuesday		Sunday	
Wednesday		Holiday Hours of Operation	
Thursday			
Friday			
24 hour on-call/after hours policy: <input type="checkbox"/> Yes <input type="checkbox"/> No			

III. Key Personnel

Manager: _____ Phone: _____

Dispatcher: _____ Phone: _____

Billing Coordinator: _____ Phone: _____

Total number of employees: _____

IV. Billing Information/Remit Information

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Tax ID: _____ NPI (if applicable): _____

Billing Email Address: _____

****Attach a copy of your W-9 or W-8 (foreign holdings only).**

V. Level of Service

Please fill in the service levels.

- | | |
|---|---|
| <input type="checkbox"/> Limousine | <input type="checkbox"/> Stretcher/Gurney |
| <input type="checkbox"/> Sedan | <input type="checkbox"/> ALS Ambulance |
| <input type="checkbox"/> Taxi | <input type="checkbox"/> BLS Ambulance |
| <input type="checkbox"/> Wheelchair Van | |

List Service/Coverage Area _____

VI. General Liability Insurance Information

****Attach a copy of current certificate of insurance and list HOMELINK as an additional insured on the certificate, which per Section III., lists HOMELINK as additional insured.**

VII. Legal Action

Please note in the event of an accident, HOMELINK requires the incident to be reported to local authorities immediately and a copy of the police report sent to HOMELINK.

Has your General Liability Insurance or coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five years? Yes No

****If Yes, attach a copy of any General Liability Insurance adverse actions for the past five years.**

Have you or any member of your Board of Directors or current employees/members ever been convicted of a felony or misdemeanor other than minor traffic violations? Yes No

****If Yes, attach a written overview.**

Have any employees that operate vehicles for your business operations ever had their driving permit limited, suspended, revoked, not renewed, or placed under probation? Yes No

****If Yes, attach a written overview.**

Do you conduct background checks on your drivers? Yes No

How often do you perform drug testing on your drivers? _____

What is your policy to verify and monitor each employee's drivers licenses? (Must certify that all drivers have valid driver's licenses and be available to up upon request.)

VIII. General Information

Does your organization have a formal program or process for the maintenance of a drug free working environment? Yes No

If no, please provide explanation: _____



Rider Bill of Rights/Provider Expectations

1. The “Rider” has a right to be treated with respect at all times by the agencies involved in the coordination and actual transport service.
2. The “Rider” has the right to refuse service from agencies if the rider deems appropriate.
3. The “Rider” has the right to expect that the coordinating agency will make every effort to restaff the service in the event that they become aware that the transportation agency is unable to provide what is requested.
4. The “Rider” has the right to be contacted regarding any changes of services within a reasonable timeframe that the coordinating agency is made aware.
5. The “Rider” has the right to complain about the service or their treatment without fear of reprisal from any entity involved in the service.
6. The “Rider” has the right to be made aware of the outcome or status of any investigations or complaints within 10 business days and resolution within 30 days if possible. If the issue exceeds thirty days, the “Rider” will be updated at least every 10 days until resolution is achieved.
7. The “Rider” has the right to be transported in a vehicle that is functionally sound and clean with appropriate safety equipment.
8. The “Rider” has the right to be transported in a vehicle that is free of air quality hazards, such as tobacco smoke, colognes, air fresheners, etc. if they are deemed by the rider to be a hazard.
9. The “Rider” has the right to be picked up at and delivered to their destinations within an acceptable timeframe.
10. The “Rider” has the right to be transported by a driver that has acceptable personal hygiene.
11. The “Rider” has the right to be able to communicate effectively with the coordinating agency and driver.
12. The “Rider” has the right to an environment free of profanity and other inappropriate language.
13. Transportation provider will perform general maintenance on all vehicles per manufacturer’s warranty guidelines. All maintenance logs will be made available to Homelink upon request.

Exhibit A

HOMELINK® Operating Policies and Procedures

HOMELINK will attempt to notify you and arrange for patient transportation, no less than 24 hours prior to the required pick-up time. However urgent arrangements for transportation may be requested.

HOMELINK will send a service confirmation fax (SCF) to you with the following information:

- HOMELINK order number
- Pick-up time
- Return trip requirements
- Type of service needed (cab, sedan, etc.)
- Rate for the service ordered
- Loaded miles
- Pick-up & destination addresses
- Authorization of wait time
- HOMELINK PCC (Patient Care Coordinator)

HOMELINK will call to confirm with your company that the fax has been received and that the transport is scheduled.

If there is a discrepancy with loaded miles, HOMELINK must be notified within 24 hours. You are required to sign the SCF and return it to HOMELINK within 24 hours following the trip. The length of wait time, if authorized, will need to be written on the SCF. This fax can serve as your bill to HOMELINK if so desired.

HOMELINK will consider your driver "on time" within 10 minutes of scheduled pick-up time. HOMELINK considers the patient "on time" following the same 10-minute rule.

Any changes in type of service must be confirmed with HOMELINK prior to the transport. Any time that a HOMELINK patient calls your company to setup transport, the trip arrangements must be called into HOMELINK for authorization prior to the transport taking place.

All HOMELINK fares are exclusive. We expect that our patient is the only fare in the vehicle and/or "no other" passengers are allowed.

Given the nature of our health care business, we adhere to a "Non-Smoking" policy on all transports.

HOMELINK expects that all drivers that are transporting our injured workers, patients, and/or family members maintain a professional appearance and demeanor, including but not limited to, appearance, attire, the vehicle, and verbal communications.

Should inclement weather prevail, your company must notify HOMELINK immediately to reschedule the trip.

If the driver experiences problems with either the patient or the trip, your company must contact the HOMELINK staff member responsible for setting up the trip.

Exhibit B

HOMELINK Payment Terms

The signed service confirmation fax (SCF) can serve as the bill for all transports. If you choose to use this as a bill, please check the box on the service confirmation fax (SCF) and fax to HOMELINK. If you use some other billing form, it must include the HOMELINK order number on the claim.

Submit claims to: HOMELINK PO Box 1860, Waterloo, IA 50704.

HOMELINK agrees to pay all clean claims within forty-five (45) days of receipt of your bill.

HOMELINK does not pay for "Patient No-Show" claims unless approved prior to the driver leaving the pick-up location. HOMELINK will consider the provider/driver a "No-Show" if he/she does not arrive as scheduled.

Loaded mileage is determined using a commercially available Internet mapping program. This mileage will be included on the service confirmation fax (SCF) sent to your company. If you disagree with the mileage listed on the fax, you must notify HOMELINK within 24 hours of the transport to justify any differences. Mileage will be paid based on the signed service confirmation fax (SCF).



HOMELINK® Credentialing Checklist

To facilitate prompt processing, please return only the forms and documents requested below. It is not necessary to provide us with costly booklets or binders as extraneous material may delay processing. If you need assistance completing this application, please contact the HOMELINK Credentialing Team at HomelinkCredentialing@vgm.com or call (866) 575-8482.

HOMELINK ATTN:
CREDENTIALING TEAM
PO BOX 1860
WATERLOO, IA 50704

- Completed HOMELINK Transportation Agreement Application
- 2 copies of your W-9
- W-8 signed (if applicable)
- Certificate of Current Auto & General Liability Insurance showing coverage of at least \$1,000,000 or the state minimum requirements for auto insurance & list HOMELINK as an additional insured on the certificate for both Auto and General Liability insurances.
- Servicing Counties:** Please attach a list of all servicing counties by state. Only a listing of specific counties will be accepted. Do not submit maps and/or regional designations (e.g., southeast Iowa, etc.)
- Copy of your Policy & Procedure that monitors current Licensed Personnel/Drivers
- Copy of current business license
- Medical Transport Service Certificates (if applicable)
- A copy of any General or Professional Liability Insurance adverse actions for the past five years.
- A summary of any convictions and/or alleged crimes for the past five years.
- A summary of any adverse sanctions or disciplinary actions (signed by owner)
- A copy of your most recent customer satisfaction survey with results and existing quality program.
- A copy of State required Worker's Compensation Certification/Training.
- A copy of your current HIPAA Compliance Policy/Privacy Statement form.

Thank you for your prompt attention to this important request.