

APPLICATION FOR PARATRANSIT PROVIDERS

- 1. Expiration Date or Effective Date (if new Business): _____
- 2. Full Name of Service: _____
- 3. Street Address: _____
- 4. City: _____ County: _____ State: _____ Zip: _____
- 5. Mailing Address (if different): _____
- 6. Phone #: _____ FAX #: _____
- 7. Email address: _____ Web address www. _____
- 8. Name of contact person: _____ Title: _____
Phone # for contact: _____
- 9. Type of Organization:
 Individual Partnership LLC Corporation- FEIN# _____
- 10. Date your service was legally established? _____*
*** if less than 3 years we will need resume on all managers/owners.**

Number of years in this type of business: _____
Number of year's current ownership: _____
Number of year's current management in place: _____
- 11. Have you ever operated under a different name? Yes No
If yes, what name: _____
- 12. Is your service a subsidiary of another company? Yes No
If yes, please explain: _____
- 13. Do you provide transportation for non-emergency medical appointments? Yes No
- 14. Do you provide public livery other than specialized transportation services for the elderly, physically challenged or mentally challenged? Yes No
If yes, please describe: _____
- 15. Is your business affiliated or associated with any transit authority? Yes No
If yes, please list which authorities: _____

16. Does your service operate any of the following?
 Taxi Cab service Limousine Service Valet/Shuttle Service
 Other (please describe): _____
17. Which service(s) does your company provide?
 Curb to Curb Door to Door Door through Door
18. Do any of your vehicles respond to emergency calls? Yes No
If yes, please explain: _____
19. Do any of your vehicles have sirens or emergency lights? Yes No
If yes, please specify which vehicle and the use: _____
20. Total estimated number of annual paratransit calls: _____
_____ % of total paratransit calls are Wheelchair
_____ % of total paratransit calls are Gurney/Stretcher
_____ % of total paratransit calls are Passenger Van
21. What is your average mileage per transport? _____ miles
22. What major cities do you provide transportation in? _____

23. Describe your driver dispatching and/or scheduling procedures: _____

24. Describe your accident review program: _____

25. Do any of your employees take the company vehicle home at night? Yes No
If yes, please describe your company policy regarding personal use of the vehicle:

26. Describe your vehicle maintenance procedures: _____

27. Fleet History/ Vehicle Count

	Current Year	Previous Year	Previous Year	Previous Year
Wheelchair Van(s)				
Gurney/Stretcher Van(s)				
Passenger Van(s)				
Totals				

28. What is your minimum driver age? _____

29. Number of currently employed drivers: _____ Full Time _____ Part Time

30. What was the percentage of your driver turnover in the past 12 months? _____%

31. Does your service review drivers motor vehicle reports? Yes No

If yes, how often? Annually Every 2-3 Years More than 3 years

32. What does your service consider as an acceptable driver motor vehicle report?

33. Describe your driver-training program: _____

Defensive Drivers Course: Film Hands-on Training

Highway Patrol Training Fail Safe Drivers Training

Road Safety Drive Cam GPS

34. What percentage of your drivers are trained in the following:

Defensive Driving Course: _____% Cardiopulmonary Resuscitation: _____%

Primary First Aid: _____% Passenger Assistance Training: _____%

EMT: _____% Paramedic: _____%

35. Does your service carry Workers Compensation and Employer's Liability Coverage?

Yes No If yes, please complete the following:

Name of Workers Compensation carrier: _____

Policy# _____ Policy Period: _____

Employers Liability Limits: Bodily Injury by Accident \$ _____, Each Accident

Bodily Injury by Disease \$ _____, Policy Limit

Bodily Injury by Disease \$ _____, Each Employee

SUPPLEMENTAL PROPERTY APPLICATION

Business Name: _____

Effective date of coverage desired: _____ Building occupied as _____

Property and Location Information: Location# _____ Building # _____

Location Street Address: _____

City: _____ State _____ Zip _____ Building Age _____

Are you a () owner, () tenant or () lessee? Total square footage of building: _____

Total square ft you occupy: _____ # of stories: _____ Sprinklered? () yes () no

Building Construction: () frame () stucco () brick () block () steel () other: _____

Any other businesses in the building?: () yes () no What Kind? _____

Do you have a burglar alarm?: () yes () no What Kind?: _____

Do you have a safe?: () yes () no What Kind?: _____

Do you have fire extinguishers and smoke detectors? () yes () no

AMOUNT OF INSURANCE REPLACEMENT COST

Building value: \$ _____ (Complete value if you own the building)

Contents, Furniture, Fixtures & Equipment (inside) Value: \$ _____

Computer Hardware Value: \$ _____ Computer Software Value: \$ _____

Deductible: () \$250 () \$500 () \$1,000

Certificate Holder: _____

Address: _____

Attn: _____ Phone#: _____ FAX#: _____

Additional Insured

Mortgagee

Loss Payee

