HOME CARE AGENCY PROVIDER CERTIFICATION OF COMPLIANCE ON PROVIDING TRANSPORTATION TO INDIVIDUALS RECEIVING MEDICAID LONG TERM SERVICES AND SUPPORTS

Please complete section I or II as it applies to your agency:	
NPI:Agency Name:	Phone:
providing transportation services to individual undersigned, acknowledges receipt of, and conditions set forth in the attached EOHHS	(insert provider name) hereinafter "Provider" intends on luals receiving 1115 home and community based services. The agrees that the Provider shall comply with all of the terms and 8 clarification guidance on Allowable Medicaid Services and es for individuals receiving 1115 home and community based
Transportation Policy. EOHHS reserves to documentation of the Provider's compliand make accessible and to maintain all record	redures in effect to assure the Provider's compliance with the he right at any time to require the Provider to provide ce with the Transportation Policy. The Provider agrees to dis relating to its compliance with the Transportation Policy to estatives, necessary to verify the accuracy of the Provider's of the Provider's to the Provider's to the Provider's of the Provider's to the Provider's to the Provider's to the Provider's to the Provider's the Provider's to the Provider's the P
transportation services to individuals rece	ovider name), hereinafter "Provider" will not be providing iving 1115 home and community based services. The Provider to provide transportation, we will complete a new Certificate of mology.
Acknowledgment The undersigned affirms that he is a duly signing and has the authority to execute this	authorized representative of the Provider for which he/she is s document on behalf of the Provider.
Authorized Agent/Signature	
Title: Print Name:	
Date:	

This form must be completed and submitted, along with the Guidance of Allowable Medicaid Services and the Authorization of Transportation Services, to DXC with Provider Enrollment Packet