Type II "Sprinter" Ambulance Grant Attestation Form

The purpose of this RFF is to enhance NEMT service delivery to members on HCBS waivers, living in their own homes and in need of basic life support (BLS) ambulance transport by expanding the available fleet of Type II “Sprinter” ambulances operated by EMS providers. This population has especially limited transportation options and experiences the highest rates of missed trips due to a lack of available providers.

This issue was identified by a higher-than-average rate of unassigned trips due to no provider being available to serve this subset of members. The issue disproportionately impacts HCBS waiver recipients, particularly those who reside in rural counties. By increasing the number of wheelchair-accessible vans, OMPP seeks to reduce the no-provider assigned rate and stabilize NEMT service delivery for this sub-group of members and waiver recipients. As a result, HCBS waiver recipients will have increased ability to access medical care and remain living in their homes.

Available Funds: A total of $3,300,000 has been allocated to this fund to purchase thirty (30) new ambulances statewide. Applicants will receive $110,000 per vehicle for the purchase of a new Type II “Sprinter” ambulance. Applicants may request to purchase up to two (2) vehicles, so long as all program requirements can be met.

Please submit any questions to hcbs.spendplan@fssa.in.gov.

* Required

* This form will record your name, please fill your name.

Awardee Information

1. Provider Name *

2. Medicaid Provider ID *

3. Provider Email *

4. Provider Phone Number *

5. Provider Address *

Provider Attestation

6. **Grant Requirements**

   Participation Requirements:

   1. Applicants must be appropriately licensed to operate ambulances and must be actively enrolled as a transportation provider in the state's Medicaid Fee for Service NEMT program, currently administered by Southeastrans, Inc.
   2. Applicants must be willing to pick up members at their own residence, i.e., home, condo, or apartment. Separate funding is available to assist members in addressing structural accessibility issues that may reduce/limit the ability of EMS to enter the residence with the necessary equipment.
   3. Applicants must complete and submit a quarterly usage report (Attachment C) and an annual impact report to OMPP.
   4. Applicants must schedule and bill for services according to the State and NEMT broker policies.
   5. Applicants agree to comply with the requirements of 2 CFR 200.313 – Equipment upon receipt of grant funds and cooperate with the appropriate State or Federal agencies to verify ongoing compliance.

   Key Ownership Requirements:

   1. The grant is limited to the purchase of <u>new Type II "Sprinter" ambulances</u>. Funds The grantee must accept full ownership responsibility for the following expenses, including but not limited to:
      1. Registration and on-going titling
      2. Fuel and routine maintenance
      3. Driver salary, training, and credentialing
      4. Repairs and unplanned maintenance
   2. The grantee must own and operate the vehicle for at least 3 years.
   3. The Provider must be actively enrolled and participate in Indiana Medicaid's Fee-forService NEMT program, currently administered by Southeastrans, Inc.
   4. The applicant must purchase the vans and lifts within 2 months of receiving notice of the award and have the vehicle in service within 4 months of purchase. If the grantee experiences any delays in receiving or installing the lift, then they must contact FSSS/OMPP to request an extension

5. If the applicant goes out of business, leaves the OMPP provider network (voluntarily or by suspension/termination) then FSSA reserves the right to request a pro-rated repayment of the initial award amount.
6. The grantee must notify FSSA within 10 business days if the vehicle is totaled in an accident and is no longer safe for use.

Timing:

1. Applicants should plan to purchase their vehicle immediately after the signed grant agreement has been executed and have the vehicle in circulation as soon as possible, unless other arrangements have been made with OMPP due to supply limitations. FSSA will issue payments as a lump sum upfront payment. The Provider must provide proof of purchase by no later than February 10, 2022.

Administrative Requirements:

1. This grant is for the purchase of goods; thus, there are no performance indicators attached to it. The Provider must provide proof of purchase and, if requested vehicle registration to OMPP. Quarterly reporting demonstrating the usage of the vehicle for Medicaid members will be required.

7. **Recommended Objectives**

    1. Accept long-distance trips of 80+ miles one-way.
    2. Agreeing to accept after-hours, evening and weekend, pick-ups related to hospital discharges.
    3. Proof that the vehicle will be purchased from an Indiana company.
    4. Service delivery to Allen, Marion, and/or Vanderburgh counties which had a larger proportional share of Type II “Sprinter” stretcher runs in 2021.
    5. Service delivery that crosses stateliness to ensure access to Medicaid approved providers in neighboring states (Illinois, Kentucky, Michigan, and/or Ohio).Service Allen, Grant, Lake, Tippecanoe, Starke and/or Vanderburgh counties.

*

The Provider understands the Recommended Objectives.

○ Yes

○ No

8. **<u>Funding Requirements</u>**

Use of Funds:

1. Funds under this award may only be used for the purchase of new Type II "Sprinter" Ambulance.

Grant Period:

1. All grants are expected to begin on or around November 18, 2022. If all funds are not utilized in the first round, FSSA may issue a second round of funding. The grant period of this funding runs until March 31, 2025. The Provider must retain ownership and operation of all vehicles purchased with these funds through the grant period end date.

Payment of Funds:

1. Payment will be made by the Medicaid fiscal agent and based upon the provider's Pay-To Address on file.

*

As the above described provider, I attest to the Funding Requirements

- Yes
- No

9. **Attestation**

    1. The above described provider agrees that by accepting the grant payment, the provider organization is subject to audit by the State of Indiana. The Provider should maintain documentation and any records to support the amount received so that it can be available upon audit.
    2. By typing my name and submitting this form, I attest that I am an agent of the Provider, whose name and information is set forth in this form, and am authorized to agree to and bind the Provider to the aforementioned terms.

    Name of Person Signing: *

10. Date of Signature: *