## ATTACHMENT A: Technical Proposal Template

### Applicant Information

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|---|
| Legal Name: |
| IHCP Provider Name (If Different Than Legal Name): |
| Medicaid Provider ID: |
| Business Address: |
| Business County: |
| Primary Contact Name: |
| Primary Contact Telephone: |
| Primary Contact E-Mail Address; |
| Counties Served: |
| Taxpayer Identification Number[1]: |
| Duns Number: |
| Congressional District: |

SIGNATURE OF AUTHORIZED REPRESENTATIVE[2]:

*To the best of my knowledge and belief, the information in this proposal has been duly authorized by the governing body of the applicant.*

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|---|
| SIGNATURE: |
| NAME/TITLE: (Typed) |
| DATE SIGNED: |

[1] Employer I.D. number or Social Security number, as appropriate, whichever is used for Federal Income Tax purposes.
[2] Refer to RFF Section II.G for additional detail

## Proposal Narrative

1. **NEMT History**
   Provide a summary of your history providing NEMT services as a provider under Southeastrans, Inc. If applicable, include any relevant information regarding your experience as a provider for an MCE or other state's broker, and/or as an independent provider before June 2019. Please detail the types of modalities your agency has accommodated (e.g., ambulatory, wheelchair, bariatric wheelchair, stretcher).

2. **Residential Service Delivery Commitment**
   FSSA is committed to helping HCBS waiver participants by offering home accessibility grants that may assist with items such as ramps, and to expanding telehealth when appropriate. However, these members must receive transportation to in-person medical appointments.
   a. Explain how your agency will be able to overcome physical access issues, increase staff knowledge of other funding to improve access and ensure that transport from residences is successfully provided when scheduled.
   b. Please list all counties that you will serve fully and/or partially and clarify level of service per county. For counties where only partial coverage is provided, please explain your specific service delivery areas and why some areas will not be covered.

3. **Sustainability & Maintenance Plan**
   Describe how you will support the maintenance and operation of your wheelchair vans and lifts.
   a. Describe your plan to provide the necessary staff to operate the service.
   b. Describe your plan to ensure the longevity and sustainability of your project beyond the grant period, which ends March 31, 2025.

4. **Priority Points – Service Delivery Qualifications**
   a. Willingness to accept long-distance trips of 80+ miles one-way.
   b. Willingness to accept after hours, evening and weekend, trips related to hospital discharges.
   c. Provide proof that the Type II "Sprinter" ambulances will be purchased from and installed by an Indiana company.
   d. Willingness to provide service in residencies located within Allen, Marion, and Vanderburgh counties.
   e. Willingness to cross stateliness to ensure access to Medicaid approved providers in neighboring states (Illinois, Kentucky, Michigan, and/or Ohio).