



Being a Transportation Provider for St. Lucie County

These are the requirements that must be met for your agency to become a transportation provider in St. Lucie County. Please be prepared to provide the following:

- Your business license and/or provide proof of a business license.
- Register with the county or city in which you plan to do business.
- Provide proof of vehicle insurance.
- Provide registration of your vehicle(s).
- Provide photos of your vehicle(s).
- Have vehicle inspected.
- Have your maintenance files inspected.
- Have your driver files inspected.
- Perform drug and alcohol testing
- Comply with local regulations.
- Provide driver license identification.
- Provide proof of driver training.
- Provide more than one employee for some services.
- Provide a roster of personnel.
- Obtain a coordination contract or agreement with the Community Transportation Coordinator.
- Comply with Chapter 14-90 of the Florida Administrative Code.
- Have documented policies and procedures.
- Report your annual operating statistics, revenues, and expenses.



St. Lucie County Transportation Coordination System Intake Form



Part I

In order to process your request for a Coordinated Contract, the following information must be completed in its entirety. Completed applications must be submitted to:

Cathi Petagno, Senior Program Specialist PetagnoC@StLucieco.org

Name _____ Title _____ Phone _____

Name of Organization: _____

Address: _____ City/State: _____

Email: _____ Fax: _____

Why are you interested in becoming a part of the St. Lucie County Coordination System?

Who referred you? APD Coordination Contractor CTC Other: _____

Service Type: Group Home Assisted Living Facility Day Program Other _____

Do you have a Med Waiver ID? Yes No Applied for date: _____

What is the Med Waiver ID # _____ Are you able to provide a copy? Yes No

Who do you provided transportation to? _____

Have you applied for a Coordination Agreement in the past? Yes No If so, when and where

AGENCY SERVICE DESCRIPTION

Part II

Provide written descriptions of the following existing conditions of your agency, for the agency's transportation service (every area must have a response). AGENCY will provide/maintain the following and notify COORDINATOR immediately of any change:

1. What existing serves do you provide?

Ambulatory	Y/N
Wheelchair	Y/N
Stretcher	Y/N

2. Days and Hours of Service:

Monday	Tuesday
Wednesday	Thursday
Friday	Saturday
Sunday	

3. Service NOT provided on: (Holidays and other days)

4. Vehicle Inventory Listing: (Make, model, year, mileage, VIN, seating capacity, color)
(attach list if necessary)

5. Vehicle Equipment Standards:

air conditioning	Y/N	grab rails	Y/N
fire extinguishers	Y/N	first aid kits	Y/N
radio communication	Y/N	securement devices	Y/N
other:			

6. Driver Qualifications and Training Requirements: Attach qualifications, licenses, required training

7. Management Transportation Experience: Attach letter

8. List Agency Staff by position: Attach list

INSURANCE REQUIREMENTS

Part III

Please make sure your Certificate of Liability Insurance – COI reflect the following:

Commercial General Liability Insurance

Combined single limit for bodily injury and property damage:

\$500,000.00 (Five Hundred Thousand Dollars) minimum limits per occurrence

\$1,000,000.00 (One Million Dollars) minimum limits per aggregate

Business Automobile Liability Insurance

Combined single limit for bodily injury and property damage:

\$500,000.00 (Five Hundred Thousand Dollars) minimum limits per occurrence

Workers' Compensation Insurance

In compliance with state statutes and all federal laws

Operations in Florida comply with Chapter 440 FSS as amended

Employer's Liability Insurance

\$100,000.00 (One Hundred Thousand Dollars) minimum limits each accident

By signing this form, you are confirming that the information is true to the best of your knowledge.

Print Name: _____

Date: _____

Applicant's Signature: _____

CTC Signature: _____

Date: _____

For Office Use Only:

Approved: **Under Review w/APD:** **On Hold:** **Comment:** _____

Staff Completing Review: _____ **Date:** _____