

# SERVICE PROVIDER AGREEMENT

Nebraska Department of Health and Human Services



## Section I

Check Appropriate Box and Write Provider Number

Agency FID **202905328**  Individual Provider Social Security Number \_\_\_\_\_

Name FID Issued To: **Shared Mobility Coach, Inc.**

## Section II

Provider Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Birthdate: \_\_\_\_\_

**SHARED MOBILITY COACH, INC.**

Provider Street Address, City, State & Zip: **2222 Cuming Street Omaha, Ne. 68102**

Mailing Address if Different from Location: \_\_\_\_\_

Business Telephone: **402-345-6640** Home Telephone: \_\_\_\_\_

Appropriate Licensure: **Yes**

Location of Service Provision if Different than Above: **designated locations authorized by case managers**

**Par. 1** This Agreement between the Nebraska Department of Health and Human Services (hereinafter the Department) and **Shared Mobility Coach, Inc.**, a service provider, governs the provision of the following service(s) checked below as defined in the Department of Health and Human Services Program Manual, Nebraska Administrative Code (NAC) Titles 404, 465, 471, 473, 474 and 480. Appropriate checklist(s) marked "Provider Addendum (name of service)" and other appropriate additions to the Agreement marked "Attachment 9A, B or C)" for contracted service is/are attached and by this reference are made part of this Agreement as if included in the contract word for word and the provider agrees to abide by all regulations as outlined in the attachment(s).

**Par. 2** Agreement Effective Date from **October 1, 2008** through **September 30, 2009**

- Par. 3** Service(s) to be provided. (See corresponding service addendum.) DD = Developmental Disabilities
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adult Day Care                    | <input type="checkbox"/> Family Support        | <input type="checkbox"/> Independence Skills Man.     |
| <input type="checkbox"/> Adult Day Health                  | <input type="checkbox"/> Habilitative Day Care | <input type="checkbox"/> Nutrition Service            |
| <input type="checkbox"/> Assisted Living                   | <input type="checkbox"/> Homemaker             | <input type="checkbox"/> PERS                         |
| <input type="checkbox"/> Assisted Technology-DD            | <input type="checkbox"/> Homemaker-DD          | <input type="checkbox"/> PERS-DD                      |
| <input type="checkbox"/> Child Care                        | <input type="checkbox"/> Home Care/Chore       | <input type="checkbox"/> Personal Assistance-Medicaid |
| <input type="checkbox"/> Community Living & Day Support-DD | <input type="checkbox"/> Home Delivered Meals  | <input checked="" type="checkbox"/> Respite Care      |
| <input type="checkbox"/> Congregate Meals                  | <input type="checkbox"/> Home Modification-DD  | <input type="checkbox"/> Vehicle Modifications-DD     |

## Section III

### Terms of Agreement

**Par. 1** If the provider violates or breaches any of the provisions of this Agreement, then this Agreement may be terminated immediately, at the election of the Department. If there are any damages arising from such violation or breach, legal remedies may be pursued to recover such damages. Any money due to the provider, which accrued prior to such violation or breach, may be offset against the damages.

**Par. 2** Under the terms of this Agreement:  
1. Staff will determine eligibility for services and authorize appropriate services for the individuals.  
2. Staff will notify provider if the service(s) being provided for a specific client is to be terminated or changed before the end of the authorization period.  
3. The Department will honor claims and make payments for services that were authorized and provided in accordance with the Department's policies and standards.

**Par. 3** This Agreement may be terminated by either party at any time by giving at least thirty days advance written notice to the other party to allow for arrangement of alternate service provision for clients. The notice requirement may be waived in case of emergencies such as illness, death, injury or fire. Only such payments as have already accrued for services rendered prior to the effective date of termination shall be made to the provider upon such voluntary termination.

**Par. 4** Subcontracting by an individual provider is not allowed under this Agreement.

**Par. 5** Service(s) will be provided using the following unit rate(s) within the maximum number of units authorized by the service area staff on a case-by-case basis.

Service Code	Service	Maximum Rate	Units
See Attachment A			

Attach documentation of basic or specialized status of Medicaid Personal Assistant.

**Par. 6** The above terms of this Agreement, Paragraphs 1 through 5 may be renegotiated upon agreement of both parties. The party requesting a change in the above terms must notify the other party at least sixty (60) days before the date the proposed change is to be implemented, except for rate changes due to minimum wage changes, rates regulated by governmental agencies or other changes required by law.

### Section IV

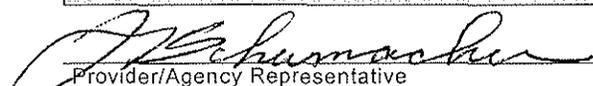
#### General Provider Standards

By signing this Agreement, the service provider agrees to:

1. Follow all applicable Nebraska Department of Health and Human Services' policies and procedures (Nebraska Administrative Code Titles 404, 465, 471, 473, 474 and 480).
2. Bill only for services which are authorized and actually provided.
3. Submit billing documents after service is provided and within 90 days.
4. Accept payment as payment in full (payment from DHHS plus the client's obligation) and assure that the rate negotiated or charged does not exceed the amount charged to private payers.
5. Not provide services if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
6. Not discriminate against any employee, applicant for employment or program participant or applicant because of race, age, color, religion, sex, handicap or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
7. Retain financial and statistical records for six years from date of service provision to support and document all claims.
8. Allow federal, state or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 – 74.24; and 42 CFR 431.107. Inspections, reviews and audits may be conducted on site.
9. Keep current any state or local license/certification required for service provision.
10. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
11. Agree and assure that any false claims (including claims submitted electronically), statement, documents or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
12. Respect every client's right to confidentiality and safeguard confidential information.
13. Understand and accept responsibility for the client's safety and property.
14. Not transfer this Agreement to any other entity or person.
15. Operate a drug free workplace.
16. Not use any federal funds received to influence agency or congressional staff.
17. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect and/or the sex offender registries.
18. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services' staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect and law violations are in place.
19. Have the knowledge, experience and/or skills necessary to perform the task(s).
20. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
21. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all the terms of this Agreement.

### Section V

  
 Provider/Agency Representative

07-1-08  
 Date

Parent or Legal Guardian Signature (if required)

  
 Signature of Authorized Representative – Nebraska Department of Health and Human Services

Date  
07-1-08  
 Date

**Nebraska Health and Human Services System  
Medicaid Home and Community-Based Services Waiver  
WAIVER PROVIDER ADDENDUM**



<b>SECTION 1</b>	<b>PROVIDER IDENTIFICATION</b>
Provider Name	Social Security or FID Number
<i>smc Shared Mobility Coach</i>	<i>502905328</i>

**SECTION 2 SERVICE STANDARDS**

       CHILD CARE FOR CHILDREN WITH DISABILITIES

1. The worker has explained 480 NAC 5-005.D to me .....	_____
2. I have completed Form DSS-0351, "Approved Day Care Home Self-Certification Checklist"; or .....	_____
3. I have completed Form DSS-0350, "In-Home Day Care Self-Certification Checklist" .....	_____
4. I have one Form DSS-0363, "Child's Record for Day Care", for each child in my care .....	_____

       TRANSPORTATION

1. The worker has explained 480 NAC 5-005.L to me .....	_____
2. I have completed Form DSS-1858, "Nebraska Public Services Commission - Nebraska Department of Social Services - Transportation Provider Self-Certification" .....	_____

*YES*

**SECTION 3 AGREEMENT AND SIGNATURES**

I understand by signing this "Waiver Provider Addendum" that I and my employees agree to meet all waiver provider standards while providing waiver services. I understand waiver services may differ in components from Social Services Block Grant services and if I provide services under both payment sources, I will meet the standards for both programs.

I agree to allow Central Registry and law enforcement checks on myself, or if an agency, I agree to allow Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.

SIGN HERE *[Signature]* *SMC / SHARED MOBILITY COACH*  
 Provider/Agency Date *09-08-09*

I have explained the above standards to this provider and she/he or the agency meets all the standards to provide the above-designated services.

SIGN HERE *[Signature]* *98-09*  
 Nebraska Health and Human Services Representative Date

**SERVICE PROVIDER AGREEMENT ATTACHMENT  
RATE AGREEMENT**

**SHARED MOBILITY COACH, INC.**

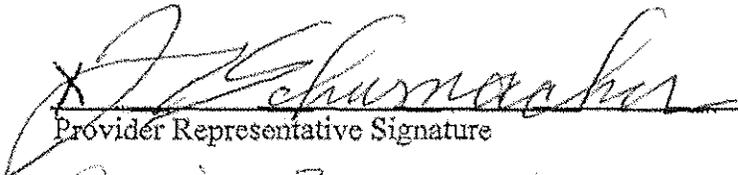
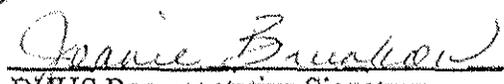
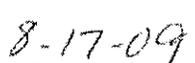
August 01, 2009 through October 15, 2009

**Omaha Metro Area (N-Focus):**

- Ambulatory passenger (Codes 7787/2979) rate is \$17.00 per one way trip.
- Wheelchair first passenger (Codes 7787/2979) rate is \$42.00 per one way trip.
- Passenger's escort/attendant rides at no charge if indicated on the prior-authorization.

**Omaha Metro Area (Medicaid):**

- Ambulatory passenger (code T2003) rate is \$17.00 per one way trip.
- Wheelchair passenger (code A0130) rate is \$42.00 per one way trip.
- Passenger's escort/attendant rides at no charge if indicated on the prior-authorization.

	
Provider Representative Signature	Date
	
DHHS Representative Signature	Date

AUG 17 2009 BLUNDO

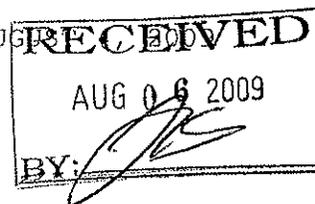
SECRETARY'S RECORD, NEBRASKA PUBLIC SERVICE COMMISSION

BEFORE THE NEBRASKA PUBLIC SERVICE COMMISSION

In the Matter of the ) APPLICATION NO. LR-303  
Prescription of Reasonable Rates )  
and Charges for Motor Carriers ) GRANTED ON AN EMERGENCY  
Passengers and Property for Hire ) BASIS  
subject to the Provisions of )  
Neb. Rev. Stat. (Reissue 2003), )  
Chapter 75, Articles 1 and 3. ) ENTERED: AUG 6 2009

BY THE COMMISSION:

OPINION AND FINDINGS



On July 9, 2009, SMC Shared Mobility Coach, Omaha, Nebraska, filed an application for authority to amend its open class rates for its use as follows:

Description	Proposed Rates
I. Base Rates: (Trips up to ten miles of point of origin)	
A. Two rates based upon:	
1. Equipment Required: lift usage for adaptive equipment.	
2. Services required: driver assistance required by the riders special needs.	
3. Time required for each individual to meet their needs: the securing required for the individual and their adaptive equipment.	
Rate 1: I. - A. \$34.00	
Rate 2: I. - A. \$47.00	
II. Mileage Rates: (Trips exceeding ten miles from point of origin)	
A. Two mileage rates based upon:	
1. Equipment required: lift usage for adaptive equipment.	
2. Services required: driver assistance required by the riders for their special needs.	
3. Time required for each individual to meet their needs: the securing required for the individual and their adaptive equipment.	
Rate 2: II. - A. \$3.04/mile	

Rate 2: II. - A. \$3.90/mile

III. Hourly rate where the driver and van are required to remain on site for an amount of time:

\$85.00/hour

Emergency action is requested.

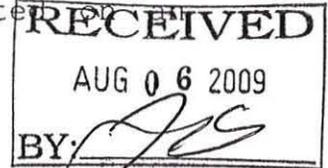
Applicant is a certificated common carrier which holds Certificate B-1669. The certificate authorizes the transportation of passengers and their baggage in vans especially modified according to the Americans with Disabilities Act who require driver assistance to board and exit the vans, and their attendants, between points within a 60 mile radius of Omaha on a flat rate basis within ten miles of the point of origin and on a mileage basis thereafter.

The Applicant last received a rate increase approximately eleven years ago. Since that time the cost of fuel has increased greatly. Other cost factors have also increased for the Applicant, most especially the cost of insurance. Increases of costs of this magnitude have a major negative effect on the operations of companies such as the Applicant.

The rates as applied for are based upon current contractual rates as approved by the Nebraska Department of Health and Human Services. The majority of the trips performed by the applicant, stated to be over ninety percent by the Applicant, are under contract with the Department. While they are a substantial increase in rates compared to current rates on file with the Commission, the Commission finds that the rates are reasonable under the circumstances of the length of time since the last increase in the Applicant's rates as well as the contractual amount in contracts with the Department of Health and Human Services.

The rates proposed are reasonable for the service provided. The application is filed in compliance with Sections 75-308 (Rates) R.R.S. 2007 and the Commission rules.

Upon consideration of the application and being fully advised in the premises, the Commission is of the opinion and finds that the application should be granted on an emergency basis effective August 10, 2009.



ORDER

IT IS, THEREFORE, ORDERED by the Nebraska Public Service Commission that, effective August 10, 2009, SMC Shared Mobility Coach, Omaha, Nebraska, be, and it is hereby, authorized to amend its open class rates for its use as follows:

Description	Rates
I. Base Rates: (Trips up to ten miles of point of origin)	
a. Two rates based upon: <ul style="list-style-type: none"> <li>i. Equipment Required: lift usage for adaptive equipment.</li> <li>ii. Services required: driver assistance required by the riders special needs.</li> <li>iii. Time required for each individual to meet their needs: the securing required for the individual and their adaptive equipment.</li> </ul>	
	Rate 1: I. - A. \$34.00
	Rate 2: I. - A. \$47.00
II. Mileage Rates: (Trips exceeding ten miles from point of origin)	
A. Two mileage rates based upon: <ul style="list-style-type: none"> <li>1. Equipment required: lift usage for adaptive equipment.</li> <li>2. Services required: driver assistance required by the riders for their special needs.</li> <li>3. Time required for each individual to meet their needs: the securing required for the individual and their adaptive equipment.</li> </ul>	
	Rate 2: II. - A. \$3.04/mile
	Rate 2: II. - A. \$3.90/mile

SECRETARY'S RECORD, NEBRASKA PUBLIC SERVICE COMMISSION

APPLICATION NO. LR-303

PAGE 4

II. Hourly rate where the driver and van are required to remain on site for an amount of time:

\$85.00/hour

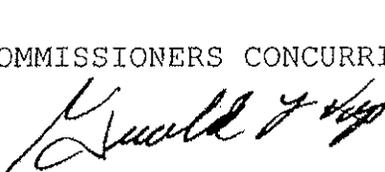
IT IS FURTHER ORDERED by the Nebraska Public Service that notice of this amendment to their rates be conspicuously displayed within each vehicle.

IT IS FURTHER ORDERED by the Nebraska Public Service Commission that public notice of this action be published in the Daily Record, Omaha, Nebraska, pursuant to the provisions of Section 75-121. R.R.S. 2007, and the Commissions Rules.

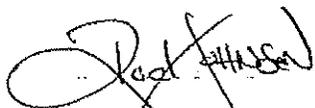
MADE AND ENTERED at Lincoln, Nebraska, this 4th day of August, 2009.

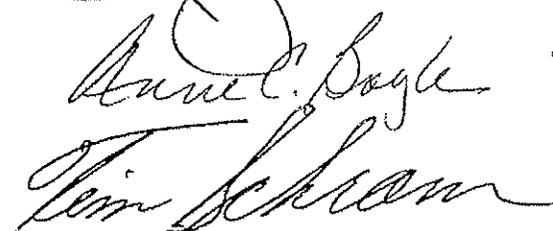
NEBRASKA PUBLIC SERVICE COMMISSION

COMMISSIONERS CONCURRING:

   
Chairman

ATTEST:

   
Executive Director

  
//s// Frank E. Landis

**Request for Taxpayer  
Identification Number and Certification**

RECEIVED JUN 20 2007

Give form to the requester. Do not send to the IRS.

Print or type  
See Specific instructions on page 2.

Name (as shown on your income tax return)

**SMC SHARED MOBILITY COACH**

Business name, if different from above

**COPY**

Check appropriate box:  Individual/Sole proprietor  Corporation  Partnership  Other

**501(C)3**

Exempt from backup withholding

Address (number, street, and apt. or suite no.)

**2022 CUMING ST.**

City, state, and ZIP code

**OMAHA, NE 68102, 4328**

Requester's name and address (optional)

List account number(s) here (optional)

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number								

or

Employer identification number								
2	1	0	2	1	9	0	5	3

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

**Sign Here**

Signature of U.S. person

*A. Schumacher*

Date

**06-20-07**

**Purpose of Form**

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

- The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
- The treaty article addressing the income.
- The article number (or location) in the tax treaty that contains the saving clause and its exceptions.