



Individual Transportation Participant (ITP) Enrollment Checklist

Use this checklist to make sure all the items needed to sign up to be an ITP are completed and submitted. **No trips will be authorized until all documents have been approved.**

For help filling out these forms, call Logisticare Contact Center at **877-633-8747**.

- A copy of your completed ITP Information Page
(Please fill out everything, and mark N/A where if a question does not apply.)
- A copy of your completed Client/ITP Information Page
- A copy of your current and valid Driver's License
- A copy of your current and valid auto insurance card
- A copy of your Social Security card
- A copy of vehicle registration and inspection

Important: The name listed on your driver's license and Social Security card must be the same.

Get your money faster with Electronic Funds Transfer (EFT)

For faster payment with direct deposit to your bank account, fill out the enclosed EFT Notification form located on page 5 of this application.

All forms must be mailed to Logisticare

ATTN: Logisticare
12234 N. Interstate 35
Plaza 35, Building B, Suite 175
Austin, TX 78753



Note: Please retain a copy for your records.

ITP Information Page		
<p>The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entire form and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted.</p>		
ITP Status: Self/Other:	Telephone Number:(if we need to contact you)	
<input type="checkbox"/> Self <input type="checkbox"/> Other	()	
<i>Must match Driver's License</i>		
Last Name :	First Name:	Middle Initial:
Social Security Number:(Please attach copy of card)	Date of Birth:	
Driver's License Number: <i>(Please attach a copy of driver's license).</i>	License Issue Date: <i>MM/DD/YYYY</i>	License Expiration Date: <i>MM/DD/YYYY</i>
Physical Address: <i>This is where you live. (You must give a street address. PO boxes will not be accepted.) Number, Street, City, State, and Zip Code</i>		
Mailing address: <i>Number, Street, City, State, and Zip Code.</i>		

Important: the name on your driver's license, social security card must be the same.

Vehicle & Insurance Information		
Vehicle Identification Number (VIN): <i>Please provide VIN of vehicle used to transport.</i>	License Tag:	
Auto Insurance Policy: <i>Please attach a copy of insurer insurance card. The vehicle used to transport the client must be listed on</i>	Policy Issue Date: <i>MM/DD/YYYY</i>	Policy Expiration Date: <i>MM/DD/YYYY</i>

<i>insurance policy.</i>		

Client/ITP Information Page

If you are driving yourself or family members only, fill out **Section 1**, leave **Section 2** blank.

If you are driving a person other than yourself or a family member, fill out **Section 1 and Section 2**.

Section 1

Client Name: <i>(the person you will be driving)</i>	Medicaid ID #:	Client DOB: <i>MM/DD/YYYY</i>	Relationship to ITP:
			<input type="checkbox"/> Family Member <input type="checkbox"/> Non-Family Member <input type="checkbox"/> Self

Section 2 *(Facts about the ITP)*

Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?

“Convicted” means that:

- (a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless of whether:
 - (1) There is a post-trial motion or an appeal pending; or
 - (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
- (b) A Federal, State or local court has made a finding of guilt against an individual;
- (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual, or
- (d) An individual has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Yes No

If Yes, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)

Terms and Condition of Participation

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1. Before an ITP drives a client, the client must get approval for the ride from Logisticare. The client must call 1-877-633-8747 to get this approval prior to the trip otherwise the ITP will not get paid.
2. The client must have the doctor sign the ITP Service Record (Claim Form) and the ITP must sign the ITP Service Record (Claim Form).
3. The mileage reimbursement (payment) amount is based on a mileage calculation computed by Logisticare using a nationally recognized system of the shortest distance of the trip and not on the number of clients who are given a ride. The ITP will be paid based on the determined mileage at the vehicle mile rate set by the Texas Legislature for state employees that is in effect at the time of the ride.
4. All payments to an ITP will be reported to the Internal Revenue Service (IRS).

5. The ITP must maintain a current and valid driver's license, vehicle insurance, vehicle inspection and vehicle registration during each ride.

6. The claim form must be submitted within 95 days from the date of the ride.

Attestation:

I attest that I have read the terms and conditions of participation as an Individual Transportation Participant (ITP) and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that HHSC or Logisticare reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

Signature of Individual Transportation Participant (ITP) _____ Date _____

Electronic Funds Transfer (EFT)

To enroll in EFT, complete the section below and attach a voided check or a signed letter from your bank on bank letterhead.

Type of Authorization:

New Change

Last Name : _____ **First Name:** _____ **Middle Initial:** _____

Address:
Street, City, State, and Zip Code.

Telephone Number:

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Bank Information:

Bank Name:	Bank Telephone:
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Bank Address:



ABA/Transit Number (Routing):	Bank Account Number:
Account Type <i>Check one</i>	
<input type="checkbox"/> Checking <input type="checkbox"/> Savings	
<p>I hereby authorize Logisticare to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I understand that I am responsible for the validity of the information on this form. If the company erroneously deposits funds into my account, I authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited.</p> <p>I understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.</p> <p>I will continue to maintain the confidentiality of records and other information relating to client in accordance with applicable state and federal laws, rules, and regulations.</p>	
Signature:	Date:

Return this Form To:

Logisticare
ATTN: Compliance
12234 N. Interstate 35
Plaza 35, Building B, Suite 175
Austin, TX 78753

