

Commonwealth of Kentucky  
Cabinet for Family and Health Services  
Department for Medicaid Services

**FOSTER PARENT**  
**Transportation  
Provider Agreement**

**To be completed by OTD  
management:**

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

**To be completed by Provider  
Services:**

Sanction checks completed by: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Each individual applying for a Kentucky Medicaid transportation provider number must complete a separate form.

\_\_\_\_\_  
(Print your full name)

\_\_\_\_\_  
(Social Security Number)

The applicant agrees to:

- Transport Medicaid recipients to and/or from medical services;
- Obey all applicable federal and state laws and regulations concerning the Kentucky Medicaid Program and the Kentucky Transportation Cabinet (driver's license, automobile/vehicle registration and insurance requirements);
- Not discriminate on the basis in the provision of services due to age, handicap, national origin, race, or sex in the provision of service.
- Keep all records of all transportation services provided to Medicaid recipients for a minimum of five (5) years (letters, statements, etc.) for review purposes;
- Notify the Cabinet for Family and Health Services, Department for Medicaid Services of any name or address change.

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

The provider or the Cabinet may terminate this agreement at any time. This constitutes the entire agreement between the Cabinet for Family and Health Services and the provider.

**APPLICANT INFORMATION:**

Original  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Driver's  
License Number: \_\_\_\_\_

Residing  
County: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Return form to:  
Lisa Wise, 275 E. Main St. 3W-C, Frankfort, KY 40621

(FOR AGENCY USE ONLY)  
Department for Medicaid Services

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Approval Date: \_\_\_\_\_

(FOR DCBS USE ONLY)

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Approval Date: \_\_\_\_\_

Background Check Completed (please circle): Y or N