

WESTCHESTER COUNTY TAXI & LIMOUSINE COMMISSION

Department of Public Safety • 112 East Post Road • White Plains, New York 10601 • (914) 995-8400

MEDICAL PROVIDER WAIVER APPLICATION

OFFICE HOURS: 9AM – 1PM MONDAY thru FRIDAY

RENEW BY MAIL

tlc.westchestergov.com

[] New	[] Renewal	[] Replacement	[] Transfer
	OFFICE	USE	ONLY	
Date Rec:	DP #			Deposit #
Applicant Fee \$	МО	СК	сс	
Fingerprint Fee \$	REC'D BY:			
	•			
	OWNER I	NFOF	RMATION	
Name of Vehicle Owner Give	full name as it appears	on th	e Title / Registration /	Lease Agreement
Social Security Number			Date of Birth	nth Day Year
Federal ID Number (Business Entities On	ly)			
Owner Address				
City/Town				
Telephone Numbers: (H) ()	(W) ()	(C) ()
Did your company provide medical transportation during the previous tax year ? [] Yes [] No If you provided medical transportation service last year then you must supply copies of IRS form 1099 as instructed on page four Of the instructions.				
If vehicle is owned by one individual, check appropriate box below and complete this form. If 2 or more owners, a partnership, or a corporation, check appropriate box and have each owner or partner and anyone owning more than 10% of stock in the corporation complete a separate owner portion of this form				
Plate #	State		Type of (Dwnership: (choose one)
VIN #			[] So	le Proprietorship
Year/Make	/Color		[] Pa	rtnership
Seating Capacity			[]Co	orporation
NYS / DOT Inspection No <u>.</u>	Inspectio	n Expi	ration Date	

NY State Department of Health Contact Information List the contact name and address of NY DOH for whom your vehicle provides transportation services.				
1. Name		Phone No	0	
Address _	Street	City	State	Zip
			otate	F

AUTHORIZED PERSONNEL INFORMATION

If the name, which appears on the DMV registration is that of a business, then this section must be completed and signed by a controlling partner, owner or authorized personnel of the business. By signing this application the person named below attests that he/she is authorized by the business to enter into an agreement on behalf of the business.

Name of Authorized Personnel				
	LAST		FIRST	MI
Title of Authorized Personnel		Date of Birth _	/ Mo Day	/ SS#
Home Address				Office Phone Number
Street Address	City	State Zi	p	

The vehicle listed herein performs transportation services for the health and / or social service organization(s) listed herein and works solely as a medical provider vehicle, as defined by §200.01.q of the Westchester County Taxi & Limousine Commission Rules and Regulations. It is understood that operating as a for-hire vehicle after being granted a WCTLC Medical Provider Waiver shall result in fines and revocation of said waiver.

In consideration of the granting of the permit hereby applied for, the applicant agrees that service of any paper, notice, letter, summons, complaint or legal process of any kind or nature may be made by the County of Westchester or any department thereof, upon the person to whom the permit is issued by leaving a copy of any such paper, notice, letter, summons, complaint, or legal process with any person located at the address designated in his/her application. It is further agreed by applicant that (s)he will conform to all rules and regulations of the Westchester County Taxi & Limousine Commission governing the type of permit for which this application is submitted. In addition, applicant understands that acceptance of this permit subjects the for-hire vehicle driven by the driver listed herein to welfare and compliance inspections.

I affirm under penalty of perjury, that I have examined this application, and to the best of

my knowledge and belief, all the information is true, correct and complete. I understand that if this application is missing or has incorrect information, my application will be rejected and that any fees I paid will not be refunded. If I want, I can re-apply with a corrected application including the required application fees. I also know that under the law, all license applications are public records and may be disclosed, including this application and all other documents and information filed with it; and I understand and agree that the Westchester County Taxi & Limousine Commission may verify any documents and information I provide, including verification of my social security number by the Social Security Administration, and Child Support case status if applicable in connection with this application. Applicant further understands that, pursuant to §210.45 of the NYS Penal Law, it is a crime punishable as a Class "A" misdemeanor to knowingly make a false statement herein.

Application Date:		Signed:	
			Applicant's Signature
State of New York) County of))ss:	Sworn to before me this	_ day of	_, 20,
			Notary Public Signature



AFFIDAVIT

NOTE TO THE MEDICAL PROVIDER APPLICANT YOU MUST SUBMIT AFFIDAVITS FROM ALL HEALTH AND / OR SOCIAL SERVICE ORGANIZATIONS YOU DO BUSINESS WITH. YOU MAY MAKE PHOTOCOPIES OF THIS FORM AS NECESSARY. THIS FORM MUST BE SIGNED AND NOTARIZED.

has filed an application for a medical provider waiver with the Westchester

(Name of vehicle owner applying for Medical Waiver)	
County Taxi & Limousine Commission (WCTLC). The applicant has stated that your organization services. Please complete this form and return it to the applicant as soon as possible.	on uses his/her vehicle(s) for transportation
1. Do you currently use the applicant's vehicle(s) for medical transportation?	[] Yes [] No
2. Does your organization uses the applicant's for any purpose other than medical transportation? If yes, provide details.	[]Yes []No
3. How long has your organization been doing business with the applicant?	YrsMos
4. Does the applicant charge your company state sales tax for its services?	[] Yes [] No
5. How often does your company use the applicant's vehicle(s)?	

Read the following and sign below.

The information listed above is complete and accurate to the best of my knowledge. I understand that, pursuant to §210.45 of the NYS Penal Law, it is a crime punishable as a Class "A" misdemeanor to knowingly make a false statement herein.

I, being duly sworn, state the following: I am the authorized personnel of the organization listed below and I am authorized to sign on behalf of the organization listed below.

Print Name of Organization:		Phone # ()	
Print Name of Authorized Per	sonnel of the Organization:	Title:	
Dated:	Signature:		
	(Au	thorized Organization Personnel)	
State of New York County of ((day of	,2,
	N	Notary Public Signature	

MEDICAL PROVIDER VEHICLE APPLICATION PROCEDURES

FOR YOUR CONVENIENCE YOU MAY RENEW BY MAIL

ALL FEES MUST BE IN THE FORM OF A MONEY ORDER, BUSINESS CHECK, or CREDIT CARD...NO CASH ACCEPTED Applications will not be processed without <u>ALL</u> of the following. Failure to comply with any of the following items will result in DENIAL of your application.

ALL APPLICATION FEES & MATERIALS ARE NON-REFUNDABLE, NON-RETURNABLE.

Supplying false information on this document may result in criminal charges being filed,

additional fees, fines, and/or denial of your application.

ITEM	INSTRUCTIONS / DOCUMENTS REQUIRED
Eligibility	Medical Provider Van/Vehicle : A medical provider <u>van</u> is a vehicle that is not wheelchair accessible and is capable of carrying 8-14 passengers for the sole purposes of transporting passengers to and from medical appointments. A medical provider <u>vehicle</u> is an automobile carrying 7 or fewer passengers for the sole purpose of transporting passengers to and from medical appointments within Westchester County. Payment for such transportation is made solely through contracts with various health or social service organizations. These organizations include, but are not limited to, Medicaid, NYS Department of Social Services, or schools/programs for the disabled.
Complete Application / Affidavit(s)	Applications will <u>not</u> be accepted if they are not completely filled out and <u>Notarized.</u> <u>Must supply original letter of authorization from the DOH</u> .
Vehicle Registration Proof of Ownership	Supply your New York State Department of Motor Vehicles Vehicle Registration, or "proof of ownership" (e.g. Title, Bill of Sale," etc.) for vehicles not previously registered with the State DMV.
Driver license	Supply a photocopy of your driver's license.
Proof of Insurance	Supply a photocopy of your <u>FH-1</u> and " <u>Acord</u> " Certificate of Liability Insurance. WCTL MUST BE NAMED AS "CERTIFICATE HOLDER" along with correct WCTLC address.
Application Fee: \$100.00	Supply a money order or business check payable to "WCTLC." For a small service fee, payment by credit card is also accepted at the service window.
Late Fee: \$75.00	Late renewal applications are required to pay a late fee.
Replacement Fee \$75.00	When replacement of vehicle permit is necessary due to loss or destruction a vehicle application must be filed and a replacement fee paid.
Fingerprinting Fee: \$90.00	First-Time applicants only. The CRIMINAL BACKGROUND FORM must also be completed.
Outstanding fees and/or fines	All outstanding fees and/or fines must be paid before submitting your application.