

Non-Emergency Medical Transportation Account Setup Agreement

INFORMATION COVER SHEET

- **ALL Transportation Providers must execute the Account Setup Agreement in order to receive payments for transportation services rendered by the provider.**
- **The terms of the Transportation Agreement shall supersede any contrary provision of this Account Setup Agreement.**
- **The Account Setup Agreement includes the following major provisions:**
 - Federal Tax ID#, or other identifying information for the Transportation Provider
 - Certification and documentation by the Transportation Provider that it meets all Federal, State and Local qualifications, credentials, and licensure to perform non-emergency medical transportation services
 - Process and time period for submission and payment of claims
 - Passenger information obtained by the Transportation Provider is subject to confidentiality provisions of the Health Information Portability and Accountability Act
 - Transportation service and billing records are subject to Medicaid and/or Medicare audit and inspection
 - Transportation Provider is an independent contractor and is neither an employee nor agent of ModivCare
 - Indemnity
- **Note: This information cover sheet is included as an information aid only and IS NOT a part of the Account Setup Agreement.**

Non-Emergency Medical Transportation Account Setup Agreement

Provider Name: City of Vicksburg, Mississippi ("Provider")

ModivCare Solutions, LLC ("MODIVCARE") and Provider enter into this Account Setup Agreement ("Agreement") based upon the following recitals, the sufficiency of which is hereby acknowledged.

ARTICLE I. PURPOSE

1.0 MODIVCARE, in its capacity as the broker of non-emergency medical transportation ("NET") services to various Clients, including Medicaid Agencies and Managed Care Organizations, intends to enter into Agreements with qualified transportation companies for the provision of high-quality transportation services, and Provider, who is in the business of performing non-emergency medical transportation services and intends to provide such services pursuant to the terms of this Agreement.

1.1 This Agreement delineates the responsibilities of MODIVCARE and Provider and the execution of this Agreement is a precondition and requirement for Provider to submit invoices to MODIVCARE and receive payment for NET services.

ARTICLE II. PARTIES ADDRESS FOR NOTICE

ModivCare Solutions, LLC.
1275 Peachtree Street, NE
Atlanta, GA 30309
Attention: SVP Contracts and Pricing
(404) 888-5800

Provider: City of Vicksburg, Mississippi
Address: 1401 Walnut Street
Address: Vicksburg, Mississippi 39180
FEIN or SS#: 64-6001174
Contact Name: Tracy Wold
Phone #: 318-548-1093

ARTICLE III. GENERAL PROVISIONS

3.0 The term of this Agreement shall be from the date of execution by signature through a period of one (1) calendar year. The Agreement shall automatically renew for additional one-year terms unless terminated by either party in accordance with the provisions of Article VIII of this Agreement.

3.1 Provider shall not sell, transfer, assign or dispose of this Agreement, in whole or in part, or any of its rights or obligations, to any other party without the express written consent of MODIVCARE, which may be withheld in MODIVCARE's sole discretion. Any attempted unauthorized assignment shall be null and void.

3.2 Any change to this Agreement will be effective only when set forth in writing and signed by an authorized representative of each party.

ARTICLE IV. SCOPE OF WORK

4.0 Provider shall provide NET service to individuals as pre-authorized by MODIVCARE.

4.1 Certifications.

a) Provider certifies and will provide conclusive documentation, as applicable, that it is in

compliance with applicable city, county, state and federal requirements regarding licensing, certification and insurance for all personnel and vehicles.

- b) Provider certifies that it carries \$ 500,000 of auto liability insurance and \$ 500,000 of commercial general liability insurance which meets or exceeds the state minimums for the vehicles used to perform Medicaid NET services. Provider shall submit current copies of its certificates of insurance indicating such auto and general liability coverage and naming ModivCare Solutions, LLC as an Additional Insured upon execution of this Agreement and upon replacement, change or renewal of either insurance policy. In addition, if requested by any Client as communicated in writing to Provider, all insurance coverage except Workers Compensation shall name Client(s) and as an Additional Insured." Additional Insured coverage shall be primary with respect to claims and co-insurance determinations. Insurance policies shall indicate that MODIVCARE will be informed in writing at least 30 days prior to any termination of or change in insurance coverage.
- c) Provider certifies that it is in compliance with applicable laws and regulation regarding federal and state exclusionary database checks, criminal background checks, and drug screens for all drivers. Criminal background checks may include fingerprinting if required by any law enforcement entity for the jurisdictions in which Provider performs NET services. Provider further certifies that all drivers meet current state and federal motor carrier safety regulations and guidelines.
- d) Provider certifies that vehicles shall comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation as well as any applicable Federal Transit Administration (FTA) regulations for the type of vehicle utilized by Provider.
- e) Provider warrants that it has never been terminated from participation in any state Medicaid or Medicare program or been determined to have committed Medicaid or Medicare fraud.
- f) Provider certifies that all information obtained regarding riders will be held in strict confidence and is used only as required in the performance of Provider's transportation services and that Provider shall comply will all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- g) ~~Provider shall maintain and utilize a GPS and/or Automated Transportation Management System ("GPS Solution") that is integrated with ModivCare systems and capable of providing real-time member pick-up and drop-off times, electronic member signature capture, electronic submission of trip claims, and real-time visibility of vehicle locations while actively transporting members. All GPS Solutions must be capable of successfully maintaining complete, accurate and timely data exchange with ModivCare, the success of which is determined by ModivCare in its sole discretion. Failure to maintain a GPS Solution that meets the above requirements is a material breach of the Agreement and ModivCare may immediately suspend all trip assignments to Provider and/or terminate the Agreement.~~
 - a. ~~Minimum Requirement: Provider shall enable location services, notifications and activate the GPS Solution application for the entirety of all ModivCare assigned trips. Provider's GPS Solutions will provide and maintain the ability to send "Real Time Events" (RTE). RTEs represent data elements that ModivCare requires to satisfy our Client service standards, ensure member safety, and meet contractual obligations.~~
 - b. ~~Provider's GPS Solution will provide, at a minimum, at least four (4) of the following RTEs: (i) On My Way, (ii) Arrival at Pick-Up, (iii) Pick-Up, (iv) Arrival at Drop Off, (v) Drop Off, and (vi) GPS data along the trip route (Breadcrumbs) from the initial On My Way RTE through completion of the trip. In addition, Provider's GPS Solution will capture and send to ModivCare member electronic / digital signature at the completion of each trip.~~

c. Provider's GPS Solution will provide, at a minimum, at least four (4) of the following RTEs: (i) On My Way, (ii) Arrival at Pick Up, (iii) Pick Up, (iv) Arrival at Drop Off, (v) Drop Off, and (vi) GPS data along the trip route (Breadcrumbs) from the initial On My Way RTE through completion of the trip. In addition, Provider's GPS Solution will capture and send to ModivCare member electronic / digital signature at the completion of each trip.

4.2 MODIVCARE and Provider agree that payments under this Agreement are strictly limited to services specifically pre-authorized by MODIVCARE.

4.3 As a condition of payment, Provider must submit accurate invoices to MODIVCARE within 90 days of date of service. Invoices not submitted within 90 days of service will be subject to a ten percent (10%) reduction in the amount that would otherwise be due under the invoice. Invoices submitted more than 120 days after date of service will be disallowed in their entirety. If Provider must first bill Medicare or other primary payer, the timeframe for submitting claims to MODIVCARE shall begin on the date of the denial of the claim by Medicare or another primary payer.

4.4 MODIVCARE processes for payment properly submitted uncontested invoices within thirty days after submission. MODIVCARE will submit payments to Provider twice per month by check or electronic transfer. Payments are inclusive of and constitute billing of all applicable state and local sales and use taxes on transportation services. Provider understands it is responsible to calculate and remit all applicable taxes on such services.

4.5 Provider shall cooperate with MODIVCARE and/or Client initiated quality assurance activities, including, but not limited to, audits to confirm persons transported pursuant to this Agreement ("Participant") attended covered medical services associated with trips invoiced by Provider. Notwithstanding any provision of the Agreement to the contrary, MODIVCARE shall only pay for transportation services when the Participant attends a Medicaid and/or Medicare covered medical service. If a trip payment to Provider is denied because a Participant did not attend an associated covered medical service, Provider may, to the extent permitted by law, directly bill the Participant for the transportation services. Any duplicate or overpayments made to Provider may be offset by MODIVCARE against future payments to Provider. MODIVCARE may offset from Provider's payments any reimbursement owned by Provider due to overpayment of claims.

4.6 Provider shall inform MODIVCARE immediately of any vehicle collision or accident that occurs while a vehicle operated by Provider is in route for a MODIVCARE assigned trip. Provider shall also inform MODIVCARE immediately of any incident resulting in injury to a Participant, or to a driver or other passenger, as well as any moving violation that occurs while providing services under this Agreement and/or any incident involving a Participant that could result in liability to Provider or MODIVCARE. The Provider shall file a written report with MODIVCARE within three (3) working days of any accident, incidents, or moving violation and shall cooperate with MODIVCARE and the Client during any ensuing investigation. Provider shall include a copy of any police reports and tickets/summons with its written report as supporting documentation.

ARTICLE V. CONFIDENTIALITY, PRIVACY, and SECURITY

5.0 Provider shall comply with all applicable laws and regulations pertaining to confidentiality, privacy, and security of proprietary and confidential information. The provisions of this section do not preclude the Provider from compliance with federal and state reporting laws and regulations. Further, these provisions also allow the Provider to fully meet reporting requirements for audit

purposes.

5.1 Provider must report a known breach of confidentiality, privacy, or security, as defined under HIPAA, to the MODIVCARE HIPAA Privacy and Security Officer at 1 (800) 486-7647, within 48 hours of becoming aware of said breach. Failure to perform may constitute cause for immediate termination of this Agreement.

ARTICLE VI. INDEMNIFICATION.

6.0 Except if Provider is an agency of the state or local government and is precluded by law or regulation from contractual indemnity, Provider shall indemnify, protect, and hold MODIVCARE and Client(s) harmless from and against any and all claims or liabilities of any kind or nature whatsoever related to or arising or alleged to arise from actions connected with services provided by or at the direction of Provider or its agents, including the cost of reasonable attorney fees and other expenses incurred by or assessed against MODIVCARE and/or the Client. This indemnity provision includes, but is not limited to, claims by drivers alleging MODIVCARE to be a statutory employer and related to injuries sustained by drivers in the course of providing services as assigned by Provider.

ARTICLE VII. AUDIT AND INSPECTION

7.0 Provider shall furnish records and information regarding any invoice(s) for service(s) to MODIVCARE, any MODIVCARE Clients, any state Medicaid Agency or Medicaid Fraud Control Unit, the Centers for Medicare and Medicaid Services ("CMS") and any representative of the U.S. Secretary of the Department of Health and Human Services ("DHHS") in compliance with applicable law or regulation. The Contractor shall not destroy or dispose of records, which are under audit, review, or investigation.

7.1 This Section 7.1 is not applicable if Provider is a public transit authority as that designation is used in 42 U.S.C. §1396a(87).

In accordance with applicable Federal regulations and CMS guidance, Provider agrees to provide copies of the following records for all drivers used to perform services under this Agreement within three (3) business days of request.

- a) Confirmation each driver is not excluded from participation in any Federal health care program (as defined in 42 U.S. Code §1320a-7b(f)) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services.
- b) Copy of each driver's valid driver's license.
- c) Copy of the driving history for each driver, including traffic violations.

In addition, any driver who violates State drug laws are prohibited from providing services under this Agreement.

ARTICLE VIII. OTHER TERMS AND CONDITIONS

8.0 The relationship between MODIVCARE and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship including one of employer and employee or principle and agent or joint venture or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Provider is solely responsible for the management, compensation, and payment of employment related taxes and insurance for its employees, including but not limited to workers' compensation and unemployment insurance.

8.1 If Provider is also a participating network provider for MODIVCARE pursuant to an executed Transportation Agreement, then this Agreement is subordinate to the Transportation Agreement and any provisions of this Agreement that are in conflict with provisions of the Transportation Agreement (including any Exhibits thereto) shall be considered null and void and the provisions of the Transportation Agreement shall control.

8.2 This Agreement shall be construed in accordance with and governed by the laws of the State of Georgia regardless of the forum where it may come up for construction.

Provider is a state entity and is prohibited by state law from agreeing to this provision.

ARTICLE IX. TERMINATION AND/OR REDUCTION IN SCOPE

9.0 Either party may terminate this Agreement by providing thirty (30) day written notice of termination to the other party or by providing sixty (60) day written notice if Medicare transportation services are provided through the Agreement.

9.1 In the event funding of the NET program from the State, Federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated Agreement expiration date, this Agreement may be terminated immediately upon written notification to the Provider by MODIVCARE.

9.2 Termination of this Agreement shall not release either party from any obligations set forth herein which shall survive this Agreement as noted herein or by their nature would be intended to apply after any termination.

9.3 Any determination that any provision of this Agreement or any application thereof is invalid, illegal, or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

ARTICLE X. Dispute Resolution and Arbitration

10.0 IF ANY CLAIM OR CONTROVERSY ARISING OUT OF OR RELATING TO THIS AGREEMENT CANNOT BE RESOLVED BY THE PARTIES IN THE NORMAL COURSE OF BUSINESS, EACH PARTY SHALL DESIGNATE A MEMBER OF ITS SENIOR MANAGEMENT TO MEET TO TRY TO RESOLVE THE DISPUTE. IF THE DISPUTE CANNOT BE RESOLVED IN THIS MANNER, THE DISPUTE SHALL BE REFERRED FOR BINDING ARBITRATION IN ACCORDANCE WITH THE COMMERCIAL DISPUTE ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION. EACH PARTY SHALL BEAR ITS OWN COSTS AND EXPENSES AND AN EQUAL SHARE OF THE ARBITRATORS' FEES AND OTHER ADMINISTRATIVE FEES RELATED TO THE ARBITRATION. JUDGMENT UPON AN AWARD IN ARBITRATION MAY BE ENTERED IN ANY COURT OF COMPETENT JURISDICTION, OR APPLICATION MAY BE MADE TO SUCH COURT FOR A JUDICIAL ACCEPTANCE OF THE AWARD AND ENFORCEMENT, AS THE LAW OF THE STATE HAVING JURISDICTION MAY REQUIRE OR ALLOW. NOTWITHSTANDING THE FOREGOING, NOTHING SHALL PROHIBIT LOGISTICARE FROM FILING A CROSS CLAIM OR A THIRD-PARTY CLAIM IN ANY LITIGATION OR ACTION NOT INITIATED BY THE PARTIES. THE PROVISIONS OF THIS SECTION SHALL SURVIVE THE TERMINATION OF THIS AGREEMENT. Provider is a state entity and is not permitted to enter into Arbitration agreements.

Unless otherwise indicated, this Agreement is entered into and effective on the date executed by ModivCare Solutions, LLC as specified below.

MODIVCARE SOLUTIONS, LLC

Effective Date: _____

Signature: _____

Printed Name: _____

Title: _____

PROVIDER: City of Vicksburg, Mississippi

Date: December 10, 2025

Signature: _____

Printed Name: Willis Thompson

Title: Mayor

MODIVCARE Internal Use Only

GL Code: _____

Set up in AP: Y N By: _____

SUBCONTRACTOR BUSINESS ASSOCIATE AGREEMENT

Provider Name: City of Vicksburg, Mississippi

This Subcontractor Business Associate Agreement (“Agreement”) is entered into as of December 10 2025, by and between MODV and City of Vicksburg (“Subcontractor Business Associate” or “Subcontractor”) to comply with the Privacy Rule and the Security Rule promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 through 164, and the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”).

Whereas, MODV and Subcontractor Business Associate are parties to a pre-existing agreement (the “Prior Agreement”), pursuant to which Subcontractor Business Associate provides services to MODV; Whereas, in connection with services provided under the Prior Agreement, MODV makes available to Subcontractor Business Associate certain Protected Health Information that is confidential and must be afforded special treatment and protection;

Whereas, MODV has entered into Business Associate Agreements with certain Covered Entity Clients and, pursuant to such Business Associate Agreements, MODV has agreed to maintain an agreement with each agent or subcontractor that has or will have access to the Protected Health Information which MODV creates or receives in the course of performing services for its Covered Entity Clients; and

Whereas, the parties are entering into this Agreement, the terms of which shall be part of and subject to the Prior Agreement, in order for MODV to satisfy its obligations under HIPAA and one or more Business Associate Agreements to which MODV is a party.

Now therefore, the Parties agree as follows:

1. **Definitions.** The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear.
 - a. **Covered Entity Client** shall mean an entity with whom MODV contracts for transport services which qualifies as a “Covered Entity” under 45 C.F.R. § 160.103, as amended.
 - b. **Designated Record Set** shall have the same meaning given such term under 45 C.F.R. § 164.501, as amended.
 - c. **HIPAA** shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
 - d. **HIPAA Regulations** shall mean the regulations promulgated under HIPAA by the United States Department of Health and Human Services at 45 C.F.R. Parts 160-164.
 - e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Investment Act of 2009, Public Law 111-5, enacted on February 17, 2009.
 - f. **Individual** shall mean the person who is the subject of the Protected Health Information, and shall include a person who qualifies as a personal representative of that person.
 - g. **Protected Health Information** (“PHI”) means individually identifiable health information (as defined in 45 C.F.R. § 160.103, as amended), limited to the information created or received by Subcontractor from or on behalf of MODV or MODV’s Covered Entity Clients. It includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that (a) identifies the individual; or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
 - h. **Secretary** shall mean the Secretary of the Department of Health and Human Services (“HHS”) and any other officer or employee of HHS to whom the authority involved has been delegated.
 - i. **Unsecured Protected Health Information** (“Unsecured PHI”) shall mean PHI that is not secured through the use of technology or methodology specified by the Secretary in applicable guidance.
 - j. **Breach** shall mean the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information, except where an unauthorized person to whom

such information is disclosed would not reasonably have been able to retain such information. Exceptions to this definition exist for cases in which: (1) the unauthorized acquisition, access, or use of PHI is unintentional and made by an employee or individual acting under authority of Subcontractor if such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship with Subcontractor, and such information is not further acquired, accessed, used, or disclosed; (2) an inadvertent disclosure occurs by an individual who is authorized to access PHI at Subcontractor to another similarly situated individual at Subcontractor, as long as the PHI is not further acquired, accessed, used, or disclosed without authorization; or (3) a disclosure of PHI occurs and Subcontractor has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

k. **Security Incident** shall have the meaning set forth in 45 C.F.R. § 164.304 and related Guidance promulgated by the Secretary.

l. Any terms capitalized, but not otherwise defined, in this Agreement shall have the same meaning as those terms have under HIPAA, the HIPAA Regulations, and the HITECH Act.

2. **Limits on use and Disclosure of PHI.** Subcontractor agrees that it will not use or disclose PHI for any purpose other than as expressly permitted or required by this Agreement. Subcontractor may use or disclose PHI for the following purposes:

a. As reasonably necessary to perform the services described in, and to effectuate the purposes of, the Prior Agreement, or as otherwise permitted or required under this Agreement or as Required By Law;

b. For the proper management and administration of Subcontractor's business and to carry out its legal responsibilities provided that: (i) such disclosures are Required by Law; or (ii) Subcontractor obtains in writing prior to making any disclosure to a third party (a) reasonable assurances from the third party that the PHI will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the third party; and (b) an agreement from the third party to notify Subcontractor immediately of any instance of which it is aware in which the confidentiality of the PHI has been breached; and

c. To perform Data Aggregation Services, as that term is defined by 45 C.F.R. § 164.501, on behalf of MODV.

3. **Additional Obligations:**

a. **Limits on use and Further Disclosure.** Subcontractor agrees that the Protected Health Information shall not be further used or disclosed other than as permitted or required by the Prior Agreement, as amended by this Agreement or as Required by Law.

b. **Safeguards.** Subcontractor will establish and maintain appropriate safeguards and warrants that it has established reasonable safeguards to prevent any use or disclosure of the PHI, other than as provided for by the Prior Agreement, as amended by this Agreement, or as required by Law. Without limiting the foregoing, Subcontractor agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI. Subcontractor further warrants that it will not use or disclose any PHI in any manner that will violate HIPAA Regulations if MODV engaged in such activity. Subcontractor shall specifically comply with 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316 of the Security Rule as such regulations are amended from time to time, as required by the HITECH Act. Subcontractor agrees to periodically complete a privacy and security survey, audit, and/or attestation if requested by MODV to assist MODV in auditing Subcontractor's compliance with the HIPAA Regulations.

c. **Minimum Necessary.** Subcontractor shall only request, use, and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.

d. **Reports of Improper use or Disclosure.** Subcontractor shall report to MODV, within one business day, any use or disclosure of PHI not provided for or allowed by this Agreement of which Subcontractor becomes aware. Without limiting the foregoing, Subcontractor agrees to report to MODV, within one business day, any Security Incident with respect to Electronic PHI of which it becomes aware. Such reports should be made to the designated MODV HIPAA Compliance Officer at any of the following:

ModivCare Solutions, LLC
Attn: HIPAA Compliance Officer
1275 Peachtree St., 6th Floor
Atlanta, GA 30309

Or

Telephone:
1- 800-486-7647

Or

Fax:
1-877-352-5640

e. Breach Notification. In the event of a Breach of Unsecured PHI, Subcontractor shall provide written notification to MODV of such Breach without unreasonable delay and no more than one business day from discovery of the Breach so that MODV can notify its Covered Entity Clients, if required. A Breach is treated as discovered as of the first day on which the Breach is known to Subcontractor or, by exercising reasonable diligence, would have been known to the Subcontractor. Knowledge of a Breach by a member of the workforce or other agent of the Subcontractor (other than the person committing the Breach) is imputed to Subcontractor. Consequently, Subcontractor shall implement reasonable policies and systems for discovery of Breaches and train its workforce members and agents to recognize and promptly report a Breach. Subcontractor understands and agrees that it bears the burden to prove why a Breach Notification is not required. Consequently, Subcontractor shall carefully document risk assessments and how any applicable exceptions are met.

f. Contents of Breach Notification. Subcontractor's notification to MODV of a Breach of Unsecured PHI must be written in plain language and describe: (1) what happened, including the date of the Breach and date of discovery; (2) the types of Unsecured PHI that were involved; (3) any steps individuals should take to protect themselves from potential harm resulting from the Breach; (4) what the Subcontractor is doing to investigate the Breach, to mitigate harm, and to protect against further Breaches; and (5) contact procedures for individuals to ask questions or learn additional information. The notice must also include the identification of each individual whose Unsecured PHI has been or is reasonably believed to have been Breached, if known. Subcontractor shall provide any additional information concerning the Breach as reasonably requested by MODV. Notification must be provided in writing to the designated MODV HIPAA Compliance Officer at the address and fax number above. If the Subcontractor believes that the Breach poses an imminent threat of misuse of Unsecured PHI, the Subcontractor shall also provide immediate notice to the designated MODV HIPAA Compliance Officer via telephone, email or other appropriate means. Subcontractor will make itself, and any subcontractors, agents, or employees available to MODV at no cost to MODV to testify as witnesses or otherwise in the event of litigation or administrative proceedings based upon claimed violation of HIPAA, except where Subcontractor is named an adverse party to MODV.

g. Subcontractors and Agents. Subcontractor agrees that anytime PHI is provided or made available to any subcontractors or agents, Subcontractor must enter into a Business Associate Agreement with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this Agreement. This includes without limitation any contracts with billing companies, factoring companies, or other entities to whom Subcontractor may provide its trip logs, trip manifests, or MODV billing documents.

h. Right of Access to Information. To the extent that MODV is obligated by contract or by law to provide Individuals access to Protected Health Information in a Designated Record Set, Subcontractor will provide such access to MODV within five business days of MODV's request. This right of access shall conform with and meet all of the requirements of 45 C.F.R. § 164.524.

i. Amendment and Incorporation of Amendments. Subcontractor agrees to make PHI contained in a Designated Record Set available to MODV for amendment within five business days of MODV's request and to incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526.

j. **Provide Accounting.** Subcontractor will document disclosures of PHI and information related to such disclosures as would be required for MODV or MODV's Covered Entity Clients to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Subcontractor will provide such information to MODV upon request.

k. **Access to Books and Records.** Subcontractor agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received on behalf of MODV, available to MODV and to the Secretary for purposes of determining MODV Covered Entity Client's compliance with HIPAA, HIPAA Regulations, and the HITECH Act.

l. **Return or Destruction of Information.** Upon request or at termination of this Agreement, Subcontractor agrees to return or destroy all PHI received from MODV or MODV's Covered Entity Clients, or created or received by Subcontractor on MODV's behalf. If return or destruction of the PHI is not feasible, Subcontractor agrees to extend the protections of this Agreement for as long as necessary to protect the PHI and to limit any further use or disclosure. If Subcontractor elects to destroy the PHI, it shall certify to MODV that the Protected Health Information has been destroyed.

m. **Mitigation Procedures.** Subcontractor agrees to mitigate, to the maximum extent practicable and at Subcontractor's expense, any harmful effect of the use or disclosure of PHI in a manner contrary to this Agreement or applicable law.

n. **Sanction Procedures.** Subcontractor will develop and implement a system of sanctions for any employee, subcontractor or agent who violates the terms of this Agreement or applicable law.

o. **Training.** Subcontractor will train its employees, agents, and subcontractors on the requirements of this Agreement, HIPAA, the HITECH Act, and the HIPAA Regulations, and will provide proof of such training to MODV upon request.

p. **Property Rights.** Subcontractor agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

4. **Term and Termination.** The Term of this Agreement shall commence as of the date executed by the parties, and shall terminate when all of the PHI provided to Subcontractor by MODV, or created or received by Subcontractor on behalf of MODV, is destroyed or returned to MODV, or, if it is not feasible to return or destroy, protections are extended to such information.

5. **Termination for Cause.** Upon MODV's knowledge of a material breach by Subcontractor of the terms of this Agreement, MODV shall either:

a. Provide an opportunity for Subcontractor to cure the breach or to end the violation within a time specified by MODV. Should the Subcontractor not cure the breach nor end the violation within the time specified by MODV, MODV may terminate the Prior Agreement immediately without penalty;

b. Immediately terminate the Prior Agreement if Subcontractor has breached a material term of this Agreement and cure is not possible; or

c. If neither termination nor cure is feasible, MODV shall report the violation to the Secretary.

6. **Indemnification.** Subcontractor shall indemnify and hold MODV and its Covered Entity Clients harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses of any kind whatsoever, including, without limitation attorney's fees, witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement, HIPAA, the HITECH ACT, or the HIPAA Regulations by Subcontractor, its employees, agents, or subcontractors. **To the fullest extent permitted by law.**

7. **Miscellaneous:**

a. **Binding Nature.** This Agreement shall be binding on the Parties hereto and their successors and assigns.

b. **Article Headings.** The article headings used are for reference and convenience only, and shall not enter into the interpretation of this Agreement.

c. **State Law.** To the extent any applicable state law confidentiality requirements are not pre-empted by HIPAA, Subcontractor agrees to comply with such state law requirements.

d. **Third Party Participants.** Subcontractor agrees that any of MODV's Covered Entity Clients to whom Subcontractor provides services and with whom MODV has entered into a Business Associate agreement are third party Participants of this Agreement. Notwithstanding the foregoing, no other individual or entity shall be considered a third party beneficiary of this Agreement.

e. **Amendment.** The Parties mutually agree to amend this Agreement from time to time as necessary for either party to comply with the requirements of HIPAA, the HITECH Act, and/or the HIPAA Regulations as they may be amended or revised from time to time, and any judicial, legislative, or administrative interpretation which alters or conflicts with any provisions contained herein. If the parties are unable to agree on an amendment within ten business days thereafter, MODV may terminate the Agreement immediately with written notice to Subcontractor.

f. **Conflict.** In the event of any conflict between this Agreement and the Prior Agreement as to the subject matter referenced herein, this Agreement shall control.

g. **Interpretation.** The terms of this Agreement shall be construed in light of any applicable interpretation or guidance on HIPAA, the HITECH Act, and/or the HIPAA Regulations issued by the HHS or the Office for Civil Rights from time to time. This Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, and the HIPAA Regulations. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, and the HIPAA Regulations.

h. **Independent Contractors.** Subcontractor and MODV agree that they are independent parties and not employees, partners, or party to a joint venture of any kind. Neither party shall hold itself out as the other's agent for any purpose, and shall have no authority to bind the other to any obligation.

i. **Assignment.** Subcontractor shall not assign its rights or obligations under this Agreement without the prior written consent of MODV.

IN WITNESS WHEREOF, MODV and Subcontractor have caused this Agreement to be signed and delivered by their duly authorized representatives, as of the date set forth above.

MODIVCARE SOLUTIONS, LLC

Date: _____

Signature: _____

Printed Name: _____

Title: _____

SUBCONTRACTOR

City of Vicksburg, Mississippi

(Print or Type Provider Name)

Date: December 10, 2025

Signature:

Printed Name: Willis Thompson

Title: Mayor

Part A: Disclosure of Ownership and Control
(Required by 42 C.F.R. §455.104)

Name of Provider: City of Vicksburg

1. List the name, address, social security number, and date of birth for each person with an ownership or control interest of 5% or more in the above named entity.

Name	Address	SSN	Date of Birth	Percent of Interest
N/A				

2. Indicate whether any of the persons identified above are related to another listed above as a spouse, parent, child or sibling.

Name	Name	Relationship
N/A		

3. Does any person listed in response to #1 above also have an ownership or control interest in another entity which is required to report ownership or control interest? If yes, identify the person and the name of the other entity.

Name	Name of Other Entity

4. The name, address, date of birth, and Social Security Number of any managing employee. "Managing employee" includes general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation.

Name	Address	SSN	Date of Birth
Jessica Cade	215 Bazinsky Rd, Vicksburg	428578879	01/13/1984

By signing this form, I certify that the information provided is true and correct. I will notify ModivCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name: Willis Thompson Title: Mayor
(print or type) (print or type)

Signature: _____ Date: December 10, 2025

Text of 42 C.F.R. §455.104

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) *Who must provide disclosures.* The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided.* The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided.*

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

- (i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.
- (ii) Upon the fiscal agent executing the contract with the State.
- (iii) Upon renewal or extension of the contract.
- (iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

- (i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
- (ii) Upon the managed care entity executing the contract with the State.
- (iii) Upon renewal or extension of the contract.
- (iv) Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

**Part B: Disclosure of Convictions
(Required by 42 C.F.R. § 455.106)**

Name of Provider: City of Vicksburg, Mississippi

List the name and address of each person with an ownership or control interest of 5% or more in the above named entity, or is an agent or managing employee of the above named entity, **and** has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

(NOTE: "Agent or managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.)

Name	Relationship to Provider	Date of Conviction
N/A		

By signing this form, I certify that the information provided is true and correct. I will notify ModivCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name: Willis Thompson
(print or type) Title: Mayor
(print or type)

Signature: _____ Date: December 10, 2025

Text of 42 C.F.R. §455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) *Notification to Inspector General.* (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation.* (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Part C: Disclosure of Business Transactions
(Required by 42 C.F.R. § 455.105)

TO BE COMPLETED UPON REQUEST

Name of Provider: City of Vicksburg, Mississippi

INSTRUCTIONS: Answer questions 1 and 2 and submit the requested information, if applicable, to ModivCare no more than 35 calendar days from the date on the cover letter enclosed with this form.

In compliance with 42 CFR §455.105, ModivCare will provide the information obtained from this form to Health Plans and/or State Medicaid agencies in compliance with its contractual obligations. ModivCare also is obligated to report the names of all providers who failed to complete this Disclosure Form to the applicable State Medicaid Agency or Health Plan. ModivCare may refuse to enter into a contract and may suspend or terminate an existing provider agreement if the provider fails to disclose the information required below.

1. Have you, as the provider, had any business transactions with any subcontractor totaling more than \$25,000 during the previous twelve (12) month period (12 month period ending as of the date on this request)? Yes No

If *No*, you may skip to question #2. If *Yes*, list the direct or indirect ownership of any subcontractor with whom you as the provider has had business transactions totaling more than \$25,000 during the previous twelve (12) month period (12 month period ending as of the date on this request). Attach as separate sheet if necessary.

Name and business address of Subcontractor	Provide One of the Following for the Subcontractor: SSN/EIN/TIN	Name and Address of the Owner of the Subcontractor (First/Middle/Last)	Transaction Amount

2. Have you, as the provider, had any significant business transactions with any wholly owned supplier or subcontractor totaling more than \$25,000 during the previous five (5) year period (5 year period ending as the date on this request)? Yes No

If *No*, you may skip this section. If *Yes*, please provide the information below for any significant business transactions between you as the provider and any wholly owned supplier, or between you as the provider and any subcontractor, during the last five (5) year period (5 year period ending as of the date of this request). Attach separate sheet if necessary.

“Subcontractor” means:

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

“Supplier” means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

“Significant business transaction” means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$ 25,000 and 5 percent of a provider’s total operating expenses.

Name and Business Address of Wholly Owned Supplier or Subcontractor	Provide One of the Following for the Wholly Owned Supplier or Subcontractor: SSN/EIN/TIN	Name and Address of the Owner of the Wholly Owned Supplier or Subcontractor (First/Middle/Last)	Transaction Amount

By signing this form, I certify that the information provided is true and correct. I will notify ModivCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name: Willis Thompson
(print or type) Title: Mayor
(print or type)

Signature: Date: December 10, 2025

Text of 42 C.F.R. §455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) *Provider agreements.* A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) *Denial of Federal financial participation (FFP).* (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

NOTE: See 42 C.F.R. §101 for definitions of subcontractor, supplier and significant business transaction.

**Addendum to Account Setup Agreement
Medicare Advantage Programs
Provider Agreement Requirements**

To the extent that any MODV Client offers NET services to Medicare beneficiaries, the Centers for Medicare and Medicaid Services (“CMS”) and associated laws, rules and regulations regarding the Medicare Advantage (“MA”) Program require that the Client provide for compliance of contracted network providers and their respective employees with certain MA program requirements including, without limitation, inclusion of certain mandatory provisions in MA provider participation agreements and/or associated documents including agreements between MODV and subcontracted transportation providers, as applicable. A list of some of these requirements can be found in the CMS Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Additionally, revisions to certain applicable regulations can be found in 74 Fed. Reg. 1494 (January 12, 2009) (amending 42 C.F.R. Parts 422 and 423). As such and in addition to the terms and conditions in the Agreement between MODV and Provider, Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries enrolled in MA health benefit plans. In the event of a conflict between the contract between MODV and Provider related to services rendered to Medicare beneficiaries and applicable provisions of this Medicare Advantage Program Provider Requirements Addendum (“Addendum”), this Addendum shall control.

II. Definitions. For purposes of this Addendum the following additional terms shall have the meaning set out below:

- (1) “**Covered Services**” means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Medicare beneficiary’s MA Plan.
- (2) “**Dual Eligible Member**” means a Medicare beneficiary who is also entitled to medical assistance under a state plan under Title XIX (“Medicaid”) of the Social Security Act (the “Act”).
- (3) “**First Tier Entity**” means ModivCare Solutions, LLC.
- (4) “**Health Plan**” means the entity that offers the MA health benefit plans with which Medicare beneficiaries participate.
- (5) “**MA Plan**” means the one or more MA health benefit plans offered or administered by Health Plan(s) for Medicare beneficiaries and under which Provider renders services to Medicare beneficiaries.
- (6) “**Medicare Advantage Program or MA Program**” means the federal Medicare managed care program for Medicare Advantage (formerly known as Medicare+Choice) products run and administered by CMS, or CMS’ successor.

(7) "Medicare Contract" means Health Plan's contract(s) with CMS to arrange for the provision of health care services to certain persons enrolled in an MA Plan who are eligible for Medicare under Title XVIII of the Social Security Act.

(8) "State" means the state in which Provider provides the Covered Services.

(9) "State Medicaid Plan" the State's plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

(10) "Medicare beneficiary" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with Health Plan.

II. Additional MA Program Obligations and Requirements. Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries.

A. Audits; Access to and Record Retention. Provider shall permit audit, evaluation and inspection directly by Health Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to services provided to Medicare beneficiaries), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the agreement under which Provider renders services to Medicare beneficiaries occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare beneficiaries to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records,

information and data necessary for: (1) Health Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by Health Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v)]

B. Privacy and Accuracy of Records. In accordance with the CMS Managed Care Manual and the regulations cited below, Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or Medicare Contract requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (i) HIPAA and the rules and regulations promulgated thereunder; (ii) 42 C.F.R. § 422.504(a)(13); and (iii) 42 C.F.R. § 422.118; (d) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable state and/or federal law, including pursuant to valid court orders or subpoenas.

C. Hold Harmless of Medicare Beneficiaries. Provider hereby agrees: (i) that in no event including, but not limited to, non-payment by Health Plan or First Tier Entity, Health Plan's determination that services were not Medically Necessary, Health Plan's or First Tier Entity's insolvency, or breach of the agreement between Provider and First Tier Entity that is the subject hereof or the agreement between First Tier Entity and Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare beneficiary for amounts that are the legal obligation of Health Plan and/or First Tier Entity; and (ii) that Medicare beneficiaries shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare beneficiaries; (b) shall survive the termination of the agreements between Provider and First Tier Entity and First Tier Entity and Health Plan regardless of the cause giving rise to such termination; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare beneficiaries, or persons acting on behalf of a Medicare beneficiary. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i)]

D. Hold Harmless of Dual Eligible Members. With respect to those Medicare beneficiaries who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill Medicare beneficiaries the balance of ("balance-bill"), and that such Medicare beneficiaries are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept First Tier Entity's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii).]

E. Accordance with Health Plan's Contractual Obligations. Provider agrees that any services provided to Medicare beneficiaries shall be consistent with and comply with the requirements of the Medicare Contract. [42 C.F.R. § 422.504(i)(3)(iii).]

F. Prompt Payment of Claims. First Tier Entity will process and pay or deny claims for Covered Services within the timeframe set forth in the agreement between Provider and First Tier Entity. [42 C.F.R. § 422.520(b).]

G. Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Medicare beneficiaries has been delegated to First Tier Entity by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements to the extent applicable to Medicare beneficiaries enrolled with Health Plan. [42 C.F.R. § 422.504(i)(5).]

H. Compliance with Health Plan's Policies and Procedures. Provider shall comply with all policies and procedures of Health Plan to the extent applicable to the services rendered by Provider. Such policies may include written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and (c) Health Plan's compliance program which encourages effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R. § 422.112; 42 C.F.R. § 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

I. Delegation (Accountability) Provisions. Provider agrees that to the extent Health Plan, in Health Plan's sole discretion, elects to delegate any administrative activities or functions to First Tier Entity, the following shall apply:

(1) Reporting Responsibilities. The Health Plan and First Tier Entity will agree in writing to a clear statement of such delegated activities and reporting responsibilities relative thereto. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(i)]

(2) Revocation. In the event CMS or Health Plan determines that First Tier Entity does not satisfactorily perform the delegated activities and any plan of correction, any and all of the delegated activities may be revoked upon notice by the Health Plan to First Tier Entity. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(ii)]

(3) Monitoring. Any delegated activities will be monitored by the Health Plan on an ongoing basis and formally reviewed by the Health Plan at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iii)]

(4) Credentialing. The credentials of medical professionals, if any, affiliated with Provider and/or First Tier Entity will either be reviewed by Health Plan or, in the event Health Plan has delegated credentialing to First Tier Entity, First Tier Entity's credentialing process will

be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iv)]

(5) **No Assignment of Responsibility.** Provider understands that Provider and/or First Tier Entity may not delegate, transfer or assign any of Provider's or First Tier Entity's obligations with respect to Medicare beneficiaries or any delegation agreement between Health Plan and Provider and/or First Tier Entity without Health Plan's prior written consent.

J. **Compliance with Laws and Regulations.** Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and with all other applicable state and federal laws, rules and regulations, as may be amended from time to time including, without limitation: (a) laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b) of the Act); (b) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; (c) Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules found at 45 C.F.R. parts 160, 162, and 164; and (d) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, and to the extent applicable, Provider agrees to maintain full participation status in the federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.204(b)(4) and 42 C.F.R. § 422.752(a)(8)]

K. **Accountability.** Provider hereby acknowledges and agrees that Health Plan oversees the provision of services by Provider to Medicare beneficiaries and that Health Plan shall be accountable under the Medicare Contract for such services regardless of any delegation of administrative activities or functions to Provider or First Tier Entity. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii)]

L. **Benefit Continuation.** Upon termination of Provider's status as a participating provider with Health Plan (unless such termination was related to safety or other concerns), Provider will continue to provide health care benefits/services to Medicare beneficiaries in a manner that ensures medically appropriate continuity of care and for the time period required by applicable law. Specifically, for Medicare beneficiaries who are hospitalized on the date of such termination, services will be provided through the applicable Medicare beneficiary's date of discharge. [42 C.F.R. § 422.504(g)(2)]. The parties acknowledge the provisions set forth in this paragraph K are not applicable to NET services.

**Addendum to Account Setup Agreement for Medicare
Advantage Program – Execution Page**

MODIVCARE SOLUTIONS, LLC

Printed Name: _____

Title: _____

Signature: _____

Date: _____

PROVIDER: City of Vicksburg, Mississippi

Printed Name: Willis Thompson

Title: Mayor

Signature:

Date: December 10, 2025



DISABLED WOMEN MINORITY BUSINESS ENTERPRISE (DWMBE) QUESTIONNAIRE

Company Name: City of Vicksburg, Mississippi Date: December 10, 2025

A **SMALL BUSINESS ENTERPRISE (SBE)** is any corporation, partnership, sole proprietorship, individual, or other business enterprise operating for profit with 100 employees or fewer, including employees employed in any subsidiary or affiliated corporation which otherwise meets the requirements of the federal small business innovation research program, except for the limitation regarding a maximum number of company employees.

Does your company qualify as a **SMALL BUSINESS ENTERPRISE?** Yes No

Is your company certified as a **SMALL BUSINESS ENTERPRISE?** *Yes No

(*If yes, please attach certificate)

A **WOMAN BUSINESS ENTERPRISE (WBE)** is at least 51% owned by a woman or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by minority group members; or any enterprise that is approved or certified as such for purposes of participation in the contracts subject to minority business enterprise requirements involving federal programs and federal funds.

Does your company qualify as a **WOMAN BUSINESS ENTERPRISE?** Yes No

Is your company certified as a **WOMAN BUSINESS ENTERPRISE?** *Yes No

(*If yes, please attach certificate)

A **MINORITY BUSINESS ENTERPRISE (MBE)** is at least 51% owned by minority group members, or in the case of a publicly owned enterprise a business enterprise that is approved or certified as such for purposes of participation in the contracts subject to women owned business enterprise requirements involving federal programs and federal funds.

Does your company qualify as a **MINORITY BUSINESS ENTERPRISE?** Yes No

Is your company certified as a **MINORITY BUSINESS ENTERPRISE?** *Yes No

(*If yes, please attach certificate)



A **DISABLED VETERAN BUSINESS ENTERPRISE (DVBE)** meets all of the following:

1. The business is at least 51 percent owned by one or more disabled veterans, or in the **case** of a publicly owned business, at least 51 percent of its stock is owned by one or more disabled veterans; a subsidiary which is wholly owned by a parent corporation but only if at least 51 percent of the voting stock of the parent corporation is owned by one or more disabled veterans; or a joint venture in which at least 51 percent of the joint venture's management and control and earnings are held by one or more disabled veterans.
2. One or more disabled veterans manage and control the daily business operations. The disabled veterans who exercise management and control are not required to be the same disabled veterans as the owners of the business concern.
3. A sole proprietorship, corporation, or partnership with its home office located in the United States, which is not a branch or subsidiary of a foreign corporation, foreign firm or other foreign-based business.

Does your company qualify as a **DISABLED VETERAN BUSINESS ENTERPRISE (DVBE)**?

Yes No

Is your company certified as a **DISABLED VETERAN BUSINESS ENTERPRISE (DVBE)**?

*Yes No

(*If yes, please attach certificate)

A **VETERAN BUSINESS ENTERPRISE (VBE)** is at least 51% owned by a veteran or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by veterans; or any enterprise that is approved or certified as such for purposes of participation in the contracts subject to minority business enterprise requirements involving federal programs and federal funds.

Does your company qualify as a **VETERAN BUSINESS ENTERPRISE (VBE)**? Yes No

Is your company certified as a **VETERAN BUSINESS ENTERPRISE (VBE)**? *Yes No

(*If yes, please attach certificate)

A **DISABLED BUSINESS ENTERPRISE (DBE)** is at least 51% owned by a disabled person, or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by disabled persons; or any enterprise that is approved or certified as such for purposes of participation in the contracts subject to minority business enterprise requirements involving federal programs and federal funds.

Does your company qualify as a **DISABLED BUSINESS ENTERPRISE (DBE)**? Yes No

Is your company certified as a **DISABLED BUSINESS ENTERPRISE (DBE)**? *Yes No

DWMBE Questionnaire

Version 1, 11/2020



modivcare

MODIVCARE PROVIDER NETWORK QUESTIONNAIRE

Please provide all the requested information to the best of your ability via fax **AND** mail the original. If you need more space, please write on the back or attach a separate sheet. Thank you.

COMPANY CONTACT INFORMATION

COMPANY NAME: City of Vicksburg

STREET ADDRESS: 1401 Walnut Street

MAILING ADDRESS: Post Office Box 150

CITY: Vicksburg STATE: MS ZIP CODE: 39180

PHONE: 601-631-3718 FAX: 601-631-3764

EMAIL: mayorwillisthompson@vicksburg.org WEB SITE: www.vicksburg.org

Which of the following best describes your company? Private Not for Profit Taxi Transit Agency

Human Services Agency Agency on Aging Faith Based Organization

NAME OF PERSON AUTHORIZED TO ENTER COMPANY INTO CONTRACTUAL OBLIGATIONS:

NAME: Willis Thompson TITLE: Mayor

PHONE #: 601-631-3718 FAX: 601-631-3764 EMAIL:
mayorwillisthompson@vicksburg.org

BASIC OPERATIONS INFORMATION

In what State do you operate? **Mississippi**

How many total vehicles do you operate in the state? 10

How many vehicles do you operate per county by type (Total must equal number above)? Please fill below:

How many drivers do you employ? 132 How many office personnel? 8 How many other? _____

Please describe your hours of operation:

Day	Hours of Operation	
	From:	To:
Monday	8:00 a.m.	8:00 p.m.
Tuesday	8:00 a.m.	8:00 p.m.
Wednesday	8:00 a.m.	8:00 p.m.
Thursday	8:00 a.m.	8:00 p.m.
Friday	8:00 a.m.	8:00 p.m.
Saturday	8:00 a.m.	8:00 p.m.
Sunday	8:00 a.m.	8:00 p.m.

What type of 2-way communication system do you use to talk to your drivers? 700/800 mhz ms w/w

Please describe your routing and dispatch technology and procedures: _____

Call s received by dispatcher and routed to appropriate ambulance

Please describe your vehicle insurance coverage limits: \$ 500,000

MEDICAL TRANSPORTATION EXPERIENCE

Do you currently provide Non-Emergency Medical Transportation (NEMT) Services? No

Please list all local, state or other permits or licenses you hold. State Ambulance

Are you licensed as an ambulance service? Yes

Have you ever been terminated from a State/Federal program or convicted of Medicaid/Medicare fraud? No

Approximately how many *WEEKLY* one-way MEDICAL trips do you currently provide? _____ Other? _____

If you would like to increase this amount, what number of *weekly one-way* trips would you like to provide? Ambulance Only

How many additional vehicles would you need to manage that level of operation? N/A

Are you able to offer services in a language other than English? If yes, please indicate the language: N/A

If you currently provide NEMT services, please list the facilities you currently serve. (Attach separate list if needed)

N/A

DRIVER MANAGEMENT

Please describe your driver hiring and screening process: Firefighter, DL check, OCA check, CEVO

Please describe your driver training and evaluation process: CEVO, DL check

QUALITY ASSURANCE PROGRAM

What steps do you take to monitor and ensure the timeliness, safety, and sensitivity of your transportation services?

Driver monitoring by clients

DWMBE STATUS

If your company qualifies, or is certified as one of the following please check the appropriate box and complete the attached DWMBE questionnaire.

Type	Check	Designation	Ownership Definition
SBE		Small Business Enterprise	Business with less than 500 employees
MBE		Disadvantaged Business	Business with 51% or more certified defined US minority ownership
WBE		Woman Owned Business Enterprise	Business with 51% or more certified woman ownership
VET		Veteran Business Enterprise	Business 51% or more certified US military veteran owned
DVBE		Disabled Veteran Business Enterprise	Business 51% or more certified disabled US veteran owned
DBE		Disabled Business Enterprise	Business 51% or more certified disabled persons owned

OTHER COMMENTS OR CLARIFICATIONS: Government

COMPLETED BY: Tracy Wan TITLE: Compliance Officer
E MAIL: tracy@itgstrategies.com TELEPHONE: 3185481093
DATE: 12/18/2025



ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

I/we hereby authorize ModivCare Solutions, LLC ("The Company") to initiate electronic credit entries to City of Vicksburg "The Company" to initiate electronic debit entries to the account listed below to correct any errors. This authority is to remain in full force and effect until "The Company" has received written notification to terminate the agreement. All changes must be submitted in writing and may require a new EFT agreement.

Section 1 (To be completed by the Transportation Provider)

Type of Transaction: Add Change Delete

Transportation Provider Name: _____
Address: _____

Telephone Number: _____
Federal Tax Identification Number: _____

Authorize Signer Name: _____

Authorize Signature: _____

Section 2 (To be completed by the Financial Institution)

Direct Deposit to be made to: _____

Financial Institution Name: _____
Address: _____

Telephone Number: _____

Routing & Transit Number/ABA #: _____

Account Number (Transportation Provider): _____

Bank Official Signature: _____ Date: _____

Section 3 (To be completed by ModivCare Solutions, LLC)

Date Received: _____ Vendor Code: _____

A/P Approval: _____ Treasury Approval: _____

PLEASE ATTACH VOIDED CHECK HERE
No Counter/Starter Checks

W-9

Form
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

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

Print or type. See Specific Instructions on page 3.	<p>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p> <p style="color: blue; font-weight: bold;">Vicksburg City Office of the City Clerk</p>					
	<p>2 Business name/disregarded entity name, if different from above</p> <p style="color: blue; font-weight: bold;">Vicksburg Warren County Ambulance Service</p>					
	<p>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► <u> </u> Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</p> <p><input type="checkbox"/> Other (see instructions) ► <u> </u></p>					
	<p>5 Address (number, street, and apt. or suite no.) See instructions.</p> <p style="color: blue; font-weight: bold;">1401 Walnut Street, P O Box 150</p>			<p>Requester's name and address (optional)</p>		
	<p>6 City, state, and ZIP code</p> <p style="color: blue; font-weight: bold;">Vicksburg, Mississippi 39181</p>					
	<p>7 List account number(s) here (optional)</p>					
	<p>Part I Taxpayer Identification Number (TIN)</p> <p>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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i>, later.</p> <p>Note: If the account is in more than one name, see the instructions for line 1. Also see <i>What Name and Number To Give the Requester</i> for guidelines on whose number to enter.</p>					

Part II Certification	<p>Under penalties of perjury, I certify that:</p> <ol style="list-style-type: none"> 1. 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 2. 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 3. I am a U.S. citizen or other U.S. person (defined below); and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. <p>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 for Part II, later.</p>
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Sign Here Signature of
U.S. person ►

Date ► **December 10, 2025**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding, later.**

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What Is FATCA reporting*, later, for further information.

Note: If you are a U.S. person and 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 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 payee 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.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester.
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying Information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; do not leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(ii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) ...	THEN check the box for ...
• Corporation	Corporation
• Individual	Individual/sole proprietor or single-member LLC
• Sole proprietorship, or	
• Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	
• LLC treated as a partnership for U.S. federal tax purposes,	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or	
• LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for ...	THEN the payment is exempt for ...
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and Its Instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.SSA.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/Businesses and clicking on Employer Identification Number (EIN) under Starting a Business. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor ²
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ The actual owner ¹
6. Sole proprietorship or disregarded entity owned by an individual	The owner ³
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i) (A))	The grantor ⁴
For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity ⁴
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominees

For this type of account:	Give name and EIN of:
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Visit www.irs.gov/identityTheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Medicare Advantage Programs Provider Agreement Requirements

To the extent that any MODV Client offers NET services to Medicare beneficiaries, the Centers for Medicare and Medicaid Services (“CMS”) and associated laws, rules and regulations regarding the Medicare Advantage (“MA”) Program require that the Client provide for compliance of contracted network providers and their respective employees with certain MA program requirements including, without limitation, inclusion of certain mandatory provisions in MA provider participation agreements and/or associated documents including agreements between MODV and subcontracted transportation providers, as applicable. A list of some of these requirements can be found in the CMS Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Additionally, revisions to certain applicable regulations can be found in 74 Fed. Reg. 1494 (January 12, 2009) (amending 42 C.F.R. Parts 422 and 423). As such and in addition to the terms and conditions in the Agreement between MODV and Provider, Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries enrolled in MA health benefit plans. In the event of a conflict between the contract between MODV and Provider related to services rendered to Medicare beneficiaries and applicable provisions of this Medicare Advantage Program Provider Requirements Addendum (“Addendum”), this Addendum shall control.

II. Definitions. For purposes of this Addendum the following additional terms shall have the meaning set out below:

- (1) **“Covered Services”** means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Medicare beneficiary’s MA Plan.
- (2) **“Dual Eligible Member”** means a Medicare beneficiary who is also entitled to medical assistance under a state plan under Title XIX (“Medicaid”) of the Social Security Act (the “Act”).
- (3) **“First Tier Entity”** means ModivCare Solutions, LLC.
- (4) **“Health Plan”** means the entity that offers the MA health benefit plans with which Medicare beneficiaries participate.
- (5) **“MA Plan”** means the one or more MA health benefit plans offered or administered by Health Plan(s) for Medicare beneficiaries and under which Provider renders services to Medicare beneficiaries.
- (6) **“Medicare Advantage Program or MA Program”** means the federal Medicare managed care program for Medicare Advantage (formerly known as Medicare+Choice) products run and administered by CMS, or CMS’ successor.

(7) “**Medicare Contract**” means Health Plan’s contract(s) with CMS to arrange for the provision of health care services to certain persons enrolled in an MA Plan who are eligible for Medicare under Title XVIII of the Social Security Act.

(8) “**State**” means the state in which Provider provides the Covered Services.

(9) “**State Medicaid Plan**” the State’s plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

(10) “**Medicare beneficiary**” means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with Health Plan.

II. Additional MA Program Obligations and Requirements. Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries.

A. **Audits; Access to and Record Retention.** Provider shall permit audit, evaluation and inspection directly by Health Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to services provided to Medicare beneficiaries), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, “Books and Records”). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the agreement under which Provider renders services to Medicare beneficiaries occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency’s designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare beneficiaries to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records,

information and data necessary for: (1) Health Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by Health Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v)]

B. Privacy and Accuracy of Records. In accordance with the CMS Managed Care Manual and the regulations cited below, Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or Medicare Contract requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (i) HIPAA and the rules and regulations promulgated thereunder; (ii) 42 C.F.R. § 422.504(a)(13); and (iii) 42 C.F.R. § 422.118; (d) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable state and/or federal law, including pursuant to valid court orders or subpoenas.

C. Hold Harmless of Medicare Beneficiaries. Provider hereby agrees: (i) that in no event including, but not limited to, non-payment by Health Plan or First Tier Entity, Health Plan's determination that services were not Medically Necessary, Health Plan's or First Tier Entity's insolvency, or breach of the agreement between Provider and First Tier Entity that is the subject hereof or the agreement between First Tier Entity and Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare beneficiary for amounts that are the legal obligation of Health Plan and/or First Tier Entity; and (ii) that Medicare beneficiaries shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare beneficiaries; (b) shall survive the termination of the agreements between Provider and First Tier Entity and First Tier Entity and Health Plan regardless of the cause giving rise to such termination; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare beneficiaries, or persons acting on behalf of a Medicare beneficiary. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i)]

D. Hold Harmless of Dual Eligible Members. With respect to those Medicare beneficiaries who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill Medicare beneficiaries the balance of ("balance-bill"), and that such Medicare beneficiaries are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept First Tier Entity's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii).]

E. Accordance with Health Plan's Contractual Obligations. Provider agrees that any services provided to Medicare beneficiaries shall be consistent with and comply with the requirements of the Medicare Contract. [42 C.F.R. § 422.504(i)(3)(iii).]

F. Prompt Payment of Claims. First Tier Entity will process and pay or deny claims for Covered Services within the timeframe set forth in the agreement between Provider and First Tier Entity. [42 C.F.R. § 422.520(b).]

G. Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Medicare beneficiaries has been delegated to First Tier Entity by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements to the extent applicable to Medicare beneficiaries enrolled with Health Plan. [42 C.F.R. § 422.504(i)(5).]

H. Compliance with Health Plan's Policies and Procedures. Provider shall comply with all policies and procedures of Health Plan to the extent applicable to the services rendered by Provider. Such policies may include written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and (c) Health Plan's compliance program which encourages effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R. § 422.112; 42 C.F.R. § 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

I. Delegation (Accountability) Provisions. Provider agrees that to the extent Health Plan, in Health Plan's sole discretion, elects to delegate any administrative activities or functions to First Tier Entity, the following shall apply:

(1) Reporting Responsibilities. The Health Plan and First Tier Entity will agree in writing to a clear statement of such delegated activities and reporting responsibilities relative thereto. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(i)]

(2) Revocation. In the event CMS or Health Plan determines that First Tier Entity does not satisfactorily perform the delegated activities and any plan of correction, any and all of the delegated activities may be revoked upon notice by the Health Plan to First Tier Entity. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(ii)]

(3) Monitoring. Any delegated activities will be monitored by the Health Plan on an ongoing basis and formally reviewed by the Health Plan at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iii)]

(4) Credentialing. The credentials of medical professionals, if any, affiliated with Provider and/or First Tier Entity will either be reviewed by Health Plan or, in the event Health Plan has delegated credentialing to First Tier Entity, First Tier Entity's credentialing process will

be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iv)]

(5) No Assignment of Responsibility. Provider understands that Provider and/or First Tier Entity may not delegate, transfer or assign any of Provider's or First Tier Entity's obligations with respect to Medicare beneficiaries or any delegation agreement between Health Plan and Provider and/or First Tier Entity without Health Plan's prior written consent.

J. Compliance with Laws and Regulations. Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and with all other applicable state and federal laws, rules and regulations, as may be amended from time to time including, without limitation: (a) laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b) of the Act); (b) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; (c) Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules found at 45 C.F.R. parts 160, 162, and 164; and (d) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, and to the extent applicable, Provider agrees to maintain full participation status in the federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.204(b)(4) and 42 C.F.R. § 422.752(a)(8)]

K. Accountability. Provider hereby acknowledges and agrees that Health Plan oversees the provision of services by Provider to Medicare beneficiaries and that Health Plan shall be accountable under the Medicare Contract for such services regardless of any delegation of administrative activities or functions to Provider or First Tier Entity. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii)]

L. Benefit Continuation. Upon termination of Provider's status as a participating provider with Health Plan (unless such termination was related to safety or other concerns), Provider will continue to provide health care benefits/services to Medicare beneficiaries in a manner that ensures medically appropriate continuity of care and for the time period required by applicable law. Specifically, for Medicare beneficiaries who are hospitalized on the date of such termination, services will be provided through the applicable Medicare beneficiary's date of discharge. [42 C.F.R. § 422.504(g)(2)]. The parties acknowledge the provisions set forth in this paragraph K are not applicable to NET services.

–See Next Page for Signatory –

**Medicare Advantage Programs
Provider Agreement Requirements**

Signature Page

MODIVCARE SOLUTIONS, LLC

Date: _____

Signature: _____

Printed Name: _____

Title: _____

PROVIDER

City of Vicksburg, Mississippi

(Print or Type Provider Name)

Date: **December 10, 2025**

Signature:

Printed Name: **Willis Thompson**

Title: **Mayor**



REQUIRED

Annual Compliance Attestation

TRANSPORTATION PROVIDER EDUCATION AND TRAINING

Modivcare is required by both federal and state regulators and by our health plan clients to communicate to and monitor specific compliance requirements of our Transportation Providers. The Centers for Medicaid and Medicare Services ("CMS"), as well as our clients, requires that all providers in the health care arena have effective education and training programs. As Modivcare's subcontractor, this requirement extends to you and your employees who provide services to Modivcare. To satisfy these requirements, Modivcare distributes training materials to its Transportation Providers to be completed upon contracting and annually thereafter that cover the below topics.

- Modivcare's Code of Conduct ("COC")
- Modivcare Transportation Provider Compliance Training (*Medicare/Medicaid General Compliance and Fraud, Waste, and Abuse, HIPAA Privacy and Security, the Americans with Disabilities Act, Health, Safety, and Welfare, and Cultural Competency.*)
- Accident/Incident Report Form & Instructions

Modivcare requests that all Transportation Provider owners and drivers that are providing services for Modivcare complete the trainings at the following link as soon as possible: <https://www.modivcare.com/tp-compliance-attestation>. Please sign the enclosed Attestation when you and your employees have completed these trainings. We realize that some Transportation Providers may have already completed substantially similar trainings this year. If this applies to you, you may rely on those trainings in completing this Modivcare attestation. Moving forward, any new employees you hire that will provide services to Modivcare must complete all of the education and training referenced in this letter within thirty (30) days of hire.

Please note, you are also responsible for maintaining records of the owners and drivers who have completed the trainings (e.g., employee acknowledgements, training rosters or certificates of completion). This evidence must be maintained for 10 years and may be requested by Modivcare at any time. An example roster is enclosed for your convenience, but you may use your own documents evidencing completion of the training and education requirements. Evidence of completion must meet the following criteria: Transportation Provider name, employee(s) full name, training/course title(s), training completion date and time, and employee signature.

We would also like to take this opportunity to remind you of your obligations under the Health Insurance Portability and Accountability Act ("HIPAA") to safeguard personal health information ("PHI"). PHI includes essentially all information about the members you transport. That includes names, pick-up and drop-off addresses, telephone numbers, Medicaid member numbers, members' conditions, levels of service, and anything else that can be used to identify the people you transport. The law requires that you keep this information confidential. In particular, do not share any trip logs, manifests, or other documents containing rider information with anyone other than Modivcare (including, but not limited to, any factoring companies). Please send any member information in an encrypted email, and dispose of any trip logs, manifests, or other documents containing rider information by shredding them before putting them in the trash. Please do not post any member information in a public forum such as an internet website.

Modivcare takes its obligation to safeguard protected health information ("PHI") and maintain program integrity very seriously. It is important that you have procedures in place to ensure that all trips are performed as required and that you do not bill for any trip that did not occur or does not meet contractual specifications. Please immediately notify Modivcare's Compliance Office at 800-894-7958 or ethics&complianceofficer@modivcare.com if you become aware of any fraud, waste, or abuse. You may also contact Modivcare's Ethics Hotline at 855-818-6929 (toll free) or online at <https://ethicshotline.modivcare.com> to report (anonymously, if you wish) suspected fraud, waste, or abuse.

If you have any questions about the trainings or the accompanying attestation, please email TPCompliance@modivcare.com. We truly appreciate the hard work you do and thank you for your cooperation and participation with Modivcare's compliance program. Thank you for your continued efforts in providing transportation to the Medicaid and Medicare members in your community. We should all take pride in our role in ensuring that these sometimes fragile and vulnerable members of our society have safe and timely access to medical care.



modivcare

Transportation Provider Compliance Attestation

On behalf of City of Vicksburg (the Transportation Provider Company) (the

"Company"), I certify that all owners and drivers providing non-emergency medical transportation services for Modivcare received, reviewed, and successfully completed the following (or substantially similar) education and training:

- Modivcare's Code of Conduct ("COC")
- Modivcare Transportation Provider Compliance Training (*Medicare/Medicaid General Compliance and Fraud, Waste, and Abuse, HIPAA Privacy and Security, the Americans with Disabilities Act, Health, Safety, and Welfare, and Cultural Competency.*)
- Accident/Incident Report Form & Instructions

I further certify that:

- The Company has had an opportunity to ask questions about the COC, the Accident/Incident Report Form, and the trainings listed above, and agrees to comply with them.
- The Company complies with all applicable local, state, and Federal laws and regulations required to provide non-emergency medical transportation services, including but not limited to driver and vehicle credentialing requirements.
- The Company maintains records (e.g., employee acknowledgements, training rosters or certificates of completion) that indicate the owners and drivers providing non-emergency medical transportation services for Modivcare have completed the training listed above for the calendar year, will retain these records for at least 10 years, and will provide them to Modivcare without charge and upon request.
- Any new employees that will provide services to Modivcare must complete all the education and trainings referenced above within thirty (30) days of hire.
- The Company shall notify Modivcare immediately of any accident, incident, and/or moving violation involving any of its drivers/vehicles providing services for Modivcare. Drivers maintain a copy of the Accident/Incident Report Form in their vehicle and will cooperate with Modivcare during any ensuing investigation.
- The Company has a conflict of interest policy or complies with the conflict of interest policy found in the COC.
- The Company does not engage in offshore operations, including any activities involving the receipt, viewing, processing, transferring, handling, storing, or accessing protected health information (as defined by HIPAA and other applicable law) outside of the United States.
- Modivcare is permitted to produce this Attestation to its state agency and managed care organization clients for purposes of demonstrating the Company's compliance with applicable laws, regulations, and contractual requirements.

As an authorized representative of an entity that has a written agreement with Modivcare, I certify that the statements above are true and correct to the best of my knowledge.

Willis Thompson, Mayor

Printed Name and Title

City of Vicksburg

Transportation Provider Company

December 10, 2025

Signature

Date

If you have any questions, please don't hesitate to contact Modivcare's Compliance Team at:

TPCompliance@modivcare.com



modivcare

Transportation Provider Training Roster

Transportation Provider Company Name: City of Vicksburg

Employee Full Name	Completion Date & Time	Employee Signature <i>(Attesting to completion of Modivcare Code of Conduct and Transportation Provider Compliance Training)</i>
NIA		

If you have multiple drivers who provide services for Modivcare and it is challenging to coordinate completion of one Roster form, please have each individual driver complete their own Roster and return to TPCompliance@modivcare.com.



Transportation Provider Manual

Acknowledgement of Receipt

I, Willis Thompson Mayor hereby
(Name) (Title)

acknowledge and that I have received a complete copy of ModivCare Solutions, Inc.'s Provider
Manual for my state on behalf of and for/

City of Vicksburg
(Legal Name of Transportation Provider)

PROVIDER:

City of Vicksburg

Printed Name: Willis Thompson

Title: Mayor

Signature: _____

Date Received: December 10, 2025