# Governmental Ambulance Provider

## PROOF OF GOVERNMENT OWNERSHIP CHECKLIST

**Provider Name:**

**Indiana Medicaid Provider Number:**

<table>
<thead>
<tr>
<th>Management’s Representation</th>
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<tr>
<td>YES</td>
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1. **Is the ambulance service owned or directly operated by a unit of government?**

2. **If yes, what unit of government owns or directly operates the ambulance service?**
   
   Please attach supporting documentation, including citation to any applicable statutory or regulatory authority

   - [ ] State
   - [ ] City
   - [ ] County
   - [ ] Special Purpose District
   - [ ] Other Governmental Unit (Specify)

3. **Please provide an attachment that describes in detail the governing structure of the ambulance service.**

   **Description of Attachment:**

4. **Does the unit of government that operates the ambulance service appropriate funding to the ambulance service?**

   Please attach documentation, including citation to any applicable statutory or regulatory authority that supports your affirmative response. Include the specific total dollar amount of the current year appropriation and the purpose of the appropriation.

   If no, please explain how the ambulance service is funded and what role, if any, the unit of government plays in providing that funding. Please attach supporting documentation.

5. **Is the ambulance service subject to audit by the State Board of Accounts?**

   YES | NO
6. Does the governmental unit have an obligation to fund the ambulance services: 
   Expenses? YES NO
   Liabilities? YES NO
   Deficits? YES NO

For each affirmative answer, please attach supporting documentation, including citation to any applicable statutory or regulatory authority.

7. Does the governmental unit have legal liability for the operation of the ambulance service? YES NO

Please attach supporting documentation, including citation to any applicable statutory or regulatory authority.

8. Does the ambulance service have the ability to make certified public expenditures to the state either directly or through the unit of government? YES NO

If yes, please explain the rationale that supports your response. Please attach supporting documentation, including citation to any applicable statutory or regulatory authority, relied on for your response.

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Certification Statement

This is to certify that the information contained herein, including any exhibits, schedules, and explanations is true, accurate and complete. Representations concerning all items have been adequately disclosed. I understand that this information is submitted for the purpose of developing reimbursement under the Indiana Medicaid Program, and that ultimate payment and satisfaction of claims will be based upon the information contained herein. I understand that any false claims, statements, or documents or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

Name of Authorized Person
__________________________________________

Signature of Authorized Person
__________________________________________

Date

Title/Position

Name of Preparer
__________________________________________

Signature of Preparer
__________________________________________

Date

Title/Position