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**Provider Information**



|                                |                     |                     |                        |
|--------------------------------|---------------------|---------------------|------------------------|
| <b>Medicaid Provider ID</b>    | 088048500 MCD       | <b>Address Type</b> | SERVICE LOCATION       |
| <b>National Provider ID</b>    | 1619071396 NPI      | <b>Address</b>      | 4980 CITY CENTER BLVD. |
| <b>Practice Type</b>           | INDIVIDUAL PRACTICE | <b>City</b>         | NORTH PORT             |
| <b>Provider Entity Type</b>    | ORGANIZATION        | <b>County</b>       | SARASOTA               |
| <b>Provider Type</b>           | 40 - AMBULANCE      | <b>State/Zip</b>    | FL 34286-0000          |
| <b>Ownership</b>               | NO                  | <b>Phone</b>        | 941-423-4353           |
| <b>Medicaid Effective Date</b> | 01/01/1976          |                     |                        |
| <b>Medicaid End Date</b>       | 06/22/2026          |                     |                        |

**Specialties**

| Primary | Provider Specialty | Specialty Description | Effective Date | End Date   | Taxonomy   |
|---------|--------------------|-----------------------|----------------|------------|------------|
| Yes     | 940                | AMBULANCE             | 01/01/1976     | 12/31/2299 | 341600000X |

**Certification and Attestation**



**Attest Type** M - SUPPLEMENTAL MINIMUM WAGE AGREEMENT ▼

The Agency for Health Care Administration (“Agency”) and the provider (“Provider”) associated with the unique identifier used to access this form on the Florida Medicaid Provider Portal enter into this Supplemental Medicaid Provider Wage Agreement (“Agreement”), with an effective date of October 1, 2022, or the effective date of the provider’s Medicaid Provider Agreement (MPA), whichever is later.

WHEREFORE, the Agency and the Provider have entered into the MPA, effective upon the date of the Provider’s enrollment in the Florida Medicaid Program, and in force as of the effective date of this supplemental wage agreement; and

WHEREFORE, The Agency and the Provider (the “Parties”) are required to enter into this Agreement to ensure that, as of October 01, 2022, or the effective date of the provider’s MPA whichever is later , all employees, including 1099 employees of the Provider, are paid at least \$15.00 per hour pursuant to the State of Florida General Appropriations Act (“GAA”) for State Fiscal Year 2022-2023; and

WHEREFORE, the Parties intend that all provisions of the underlying MPA, incorporated herein by reference, and not specifically superseded by this Agreement, shall remain in force and applicable to this Agreement.

NOW THEREFORE, in consideration of the covenants and obligations contained herein, the Parties agree to the following terms and conditions:

- (1) As of October 1, 2022, or the effective date of the provider’s MPA, whichever is later, the Provider shall pay each of its employees, including 1099 employees, at least \$15.00 per hour for the 2022 - 2023 State Fiscal Year.
- (2) The Provider agrees to permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods, and services which are relevant to this Agreement.
- (3) The Agency shall adjust Medicaid Provider Fee Schedules and Rates as directed in the GAA for State Fiscal

Year 2022-2023, and the Provider agrees to accept an increased rate from the Agency for the provision of services or goods to Medicaid recipients.

(4) Term and signatures – The provider understands and agrees that no agency signature is required to make this agreement valid and enforceable. This Agreement shall remain in effect from the Effective Date until June 30, 2023.

A Chief Executive Officer, President, or Administrator of the provider may sign this Agreement. Failure to sign the Agreement will make the Agreement voidable by the Agency.

The signatory hereto represents and warrants that they have read the Agreement, understand it, and are authorized to execute it on behalf of the provider.

**Select all items**

- \* I certify that as the signatory to this Agreement, acting in a representative capacity, I am duly authorized to enter into this Agreement on behalf of the Provider to which the unique identifier used to access this form on the Medicaid Provider Portal is assigned.
- \* On behalf of the Provider, I attest under the penalty of perjury pursuant to section 837.012, Florida Statutes, that as of October 1, 2022, or the effective date of the provider’s MPA whichever is later, all employees impacted by the requirements of the 2022-2023 General Appropriations Act, including employees defined as 1099 workers, will be paid at least \$15.00 per hour.
- \* I understand that if I am a provider with multiple locations, I will be required to complete this form separately for each location.

IN WITNESS WHEREOF, the undersigned representative has caused this agreement to be duly executed as October 1, 2022, or the effective date of the provider's MPA whichever is later.

Effective Date\* 10/01/2022

End Date\* 06/30/2023

Date Signed 08/31/2022

Signed By\*