Georgia Department of Community Health

In-State Governmental Ambulance Provider
Proof of Government Ownership Checklist

Please provide a response to each question below and include explanations and supporting documentation where indicated.

Provider Name: _____
Georgia Medicaid Provider No.: _____
State Fiscal Year (SFY): _____

Management's Representation

1) Is the ambulance service owned by a unit of government or a healthcare provider that is owned by a unit of government, i.e. a county-owned hospital? ☐ Yes ☐ No

a) If yes, what unit of government owns the ambulance service?

- ☐ Hospital Authority
- ☐ State
- ☐ City
- ☐ County
- ☐ Special Purpose District
- ☐ Other Governmental Unit (Specify): _____

2) Does the unit of government that owns the ambulance service appropriate funding to the ambulance service? ☐ Yes ☐ No

a) **If yes**, please attach documentation such as a city or county ordinance, board meeting minutes, an appropriation report for the ambulance service fund for the current year, or other form of documentation describing the funding arrangement.

Description of attachment: _____

b) **If no**, please explain how the ambulance service is funded and what role, if any, the unit of government plays in providing that funding.

Explanation: _____

3) Is the ambulance service subject to audit by the Georgia Department of Audits and Accounts (DOAA)? ☐ Yes ☐ No

4) Does the governmental unit have legal liability for the operation of the ambulance service? ☐ Yes ☐ No

5) Does the ambulance service have the ability to make intergovernmental transfers (IGTs) to the state either directly or through the unit of government identified in the response to question 1? ☐ Yes ☐ No

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 Georgia 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.

_____
Printed Name of Authorized Person: **Title/Position**

_____
Signature of Authorized Person: **Date**

_____
Printed Name of Preparer (if applicable): **Title/Position**

_____
Signature of Preparer (if applicable): **Date**