

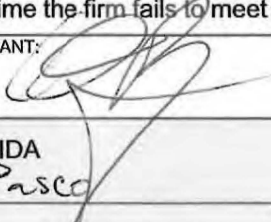
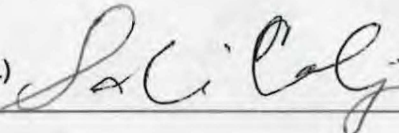
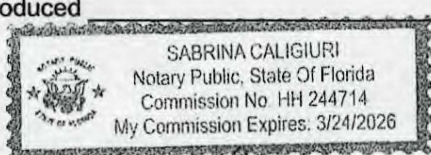


APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

APPLICATION TYPE: ☒ NEW ☐ RENEWAL

SERVICE TYPE: ☒ Wheelchair Transport ☐ ALS Interfacility ☐ ALS Non-Transport
☐ Stretcher Transport ☐ ALS Helicopter ☐ ALS Transport

TYPE OF ENTITY: ☒ Sole Proprietor ☐ Partnership ☐ Non-Profit Corporation ☐ Corporation

ORGANIZATION NAME: <u>TrueCare Transport LLC</u>		HOURS OF OPERATION: <input checked="" type="checkbox"/> 24-HOUR A.M. to <input type="checkbox"/> A.M. / <input type="checkbox"/> P.M.
ADDRESS 1: <u>15985 Preserve Market</u>		PHONE: <u>813-373-2606</u>
ADDRESS 2: <u>Place #1018</u>		FAX:
CITY, STATE, ZIP CODE: <u>Odessa, Florida</u>		
OFFICER/DIRECTOR NAME & TITLE: <u>Arlis Fuentes Perez</u>	PHONE NUMBER & E-MAIL: <u>239-302-8273</u> <u>trucaretransport17@gmail.com</u>	
VICE OFFICER/DIRECTOR NAME & TITLE: <u>Oneida Fuentes</u>	PHONE NUMBER & E-MAIL: <u>813-373-2606</u> <u>trucaretransport17@gmail.com</u>	
BUSINESS HOURS POINT-OF-CONTACT: <u>Oneida Fuentes</u>	PHONE NUMBER & E-MAIL: <u>813-373-2606</u> <u>Same</u>	
AFTER HOURS POINT-OF-CONTACT: <u>Oneida Fuentes</u>	PHONE NUMBER & E-MAIL: <u>813-373-2606</u> <u>Same</u>	
REQUIRED ATTACHMENTS: Record Keeping Verification Form, Vehicle Roster(s), Driver Roster(s), Certificate of Incorporation, Certification of Fictitious Name (d.b.a) if applicable, Insurance Verification for the highest level of service provided, and retail rate schedule. Also include any new applications per County Driver Certification Requirements.		
I, the undersigned representative of the above named firm, do hereby acknowledge this certificate may be suspended or revoked if at any time the firm fails to meet all of the requirements of the Pinellas County Code or Rules and Regulations.		
SIGNATURE OF APPLICANT: 		DATE: <u>03/6/2025</u>
STATE OF FLORIDA COUNTY OF <u>Pasco</u>		
Subscribed and sworn to (or affirmed) before me this <u>June 3, 2025</u> by <u>Arlis Fuentes Perez</u> , who is/are personally known to me or has/have produced _____ as identification.		
(SEAL) 	 <u>Sabrina Caligiuri</u> (Name of Notary typed, printed or Form stamped)	

COPCN (Form A)

Section 1

Application Type

Wheelchair Transport

Initial



Renewal

Stretcher Transport



ALS Helicopter



ALS Interfacility



ALS Non-Transport



ALS Transport



Type of Entity

*Type of Entity

☒ Sole Proprietor☐ Partnership☐ Non-Profit Corporation☐ Corporation

Organization Type

Sole Proprietor

**Company Information (Form A)**

Company Information

Organization Name

TruCare Transport

*Street 1

15985 Preserve Marketplace #1018

Street 2

15985 Preserve MarketPlace #1018

*Postal Code

33556

City

Odessa

State

Florida



Phone

813 - 373 - 2606 Ext:

Fax

*Hours of operation

24/7

Company Contacts

Position

☐ Officer/Director

*Action to take

Update record in the service

This is the action that will be taken within the service for the User you select below.

*Search Contact

Fuentes Perez, Arlis (560001)

*Work Phone

813 - 373 - 2606 Ext:

Email

trucairetransport17@gmail.com

Position

☒ Vice Officer/Director

*Search Contact

Fuentes Perez, Arlis (560001)

*Work Phone

813 - 373 - 2606 Ext:

*Email

trucairetransport17@gmail.com

Position

☒ Business Hours Point-of-Contact

*Search Contact

Fuentes Perez, Arlis (560001)

*Work Phone

813 - 373 - 2606 Ext:

*Email

trucairetransport17@gmail.com

Position

☒ After Hours Point-of-Contact

*User

Fuentes Perez, Arlis (560001)



*Work Phone

813 - 373 - 2606 Ext:

*Email

trucairetransport17@gmail.com

Record Keeping Verification Form (Form B)

Inspection Items

Section 8.1

Record all telephone lines when used for requests for transport, including cell phones.*

*Initials

of

*Initial here if standard business practice is to receive requests via fax and/or e-mail and written records are maintained of such contacts in accordance with written records criteria.

*Initials

of

Section 8.1

Written record contains:

- Date Call Received
- Time Call Received
- Pick-up & Destination Address
- Arrival Time at Destination
- Client's Name
- Person Ordering Transport
- Telephone Number of Caller (*if applicable)

*Initials

of

Section 8.1

Audio dispatch records shall be kept for a minimum of six (6) months.

*Initials

Of

Section 8.1

Written or electronic dispatch shall be kept for a minimum of three (3) years.

*Initials

Of

Section 8.1

Dispatch audio & written/electronic records shall be available for inspection.

*Initials

of

Vehicles (Form C)

Section 1

*Vehicle

[New]

Unit Number

10

Vehicle Tag Number

26EBMJ

*Vehicle Identification Number(VIN)

1FTSS3LXEDA86201

*Active

☒ Yes ☐ No

Personnel (Form D)

Section 1

Personnel ID

560001

User

Fuentes Perez, Arlis (560001)

Position

☐ Pinellas County EMS Training Coordinator

☐ EMS Coordinator

☒ Primary Contact

☒ Operations Officer

☐ Medical Director (On-Line)

☐ Medical Director (Off-Line)

☐ Service Director

☐ Assistant Service Director

☐ Service Representative

☐ Primary QA Contact

☐ Infection Control Officer

☐ Fire Administration

☐ Fire Marshall

☐ Fire Chief

☐ Agency Admin Support

☐ CCT Coordinator

☐ SWAT Supervisor


- ☐ Sunstar Supervisor
- ☐ EMS Chief
- ☐ Sunstar Admin Support
- ☐ Fire Inspector
- ☐ Fire Coordinator
- ☐ WCT Admin Support
- ☐ Officer/Director
- ☐ Vice Officer/Director
- ☐ Business Hours Point-of-Contact
- ☐ After Hours Point-of-Contact

Required Documents

Insurance verification

Provide a copy of the Certificate of Insurance showing limits for the highest level of service provided detailing vehicle liability, property damage coverage, and the expiration date of the policy (See Rules & Regulations 8.2)

Policy Type

Policy 

Number

CPS8110274 - PC24112087

Issued Date

11/22/2024 [Today](#)

Expiration Date

11/22/2025 [Today](#)

***Insurance Verification**

 [Change File](#) 2025-05-17_095277.pdf

Name

Insurance Verification

Document Type

Insurance Verification 

Certificate of Incorporation



WHEELCHAIR / STRETCHER DRIVER ROSTER
Pinellas County Rules and Regulations, as Amended

Name of Service: TauCare Transport LLC Page: ____ of ____

Attach a copy of the Class E Driver's License for each listed Driver. If more lines are needed, it is acceptable to copy this form. A Company Roster may be attached, as long as all required information is included.

	Name (Last, First) Also list "nick-name" if applicable	Class E Driver's License Number	Expiration Date	Date of Birth	Assigned EMS ID #
1.	Ardis Fuentes Perez	F614-313-06-100-0	12/17/31	12/17/1981	56001
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

*Certificate of Incorporation

[📎 Change File](#) 2025-05-27_112614.pdf

Name

Certificate of Incorporation

Document Type

Certificate of Incorporation



Retail Rate Schedule

*Retail Rate Schedule

[📎 Change File](#) 2025-05-15_115128.pdf

Name

Retail Rate Schedule

Document Type

Retail Rate Schedule



Certification of Fictitious Name (d.b.a.)

Please upload a copy of your Certification of Fictitious Name (d.b.a.).

Certification of Fictitious Name

[📎 Upload File](#)

Name

Certification of Fictitious Name

Document Type

Certification of Fictitious Name



Signature

Signature

*Today's Date

05/27/2025

[Today](#)

*Signature

Signed on May 27, 2025 11:42:05 AM by Arlis Fuentes Perez



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

05/15/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER G. Zein Insurance Services 409 w. hallandale beach blvd Ste 215 Hallandale Beach FL 33009		CONTACT NAME: George Zein PHONE (A/C, No, Ext): (954) 454-9599 E-MAIL ADDRESS: g.zein@floridainsurance.ws FAX (A/C, No): (954) 843-0313	
INSURED TRUCARE Transport LLC 15985 Preserve Market Place #1018 Odessa FL 33556		INSURER(S) AFFORDING COVERAGE INSURER A: SCOTTSDALE INSURANCE INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES**CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC <input checked="" type="checkbox"/> OTHER: Loading/Unloading:\$15,00		CPS8110274	11/22/2024	11/22/2025	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 SEXUAL ABUSE \$ 100,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y <input checked="" type="checkbox"/> N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

NON EMERGENCY MEDICAL TRANSPORTATION

LIST OF DRIVERS: Arlis Fuentes, Oneida Fuentes

LIST OF VEHICLE: 2014 Ford Econoline - VIN# 1FTSS3LXEDA86201

Certificate Holder: Pinellas County

CERTIFICATE HOLDER**CANCELLATION**

Pinellas County

A Political Subdivision of the State of Florida

400 South Fort Harrison Ave

Clearwater

FL 33756

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF INSURANCE				DATE (MM/DD/YY) 12/02/2024
PRODUCER AND THE NAMED INSURED Prime Property & Casualty Insurance Inc. 8722 S. Harrison St. Sandy, UT 84070 (801) 304-5500		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE OF INSURANCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND, OR ALTER THE COVERAGE AFFORDED BY THE INSURANCE POLICIES BELOW.		
INSURED Tricare Transport LLC DBA: 2967 Suncoast Blend Dr Odessa, FL 33556		INSURERS AFFORDING COVERAGE INSURER A: Prime Property & Casualty Insurance Inc. INSURER B: INSURER C: - Company #27876		
COVERAGES		"LIMITS SHOWN ARE THOSE IN EFFECT AS OF POLICY INCEPTION"		753249
The policies of insurance listed below have been issued to the insured named above for the policy indicated. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies. Aggregate limits shown may have been reduced by paid claims.				
TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
<input type="checkbox"/> <u>Commercial Liability</u> <input type="checkbox"/> Claims Made <input type="checkbox"/> Exclude Products <input type="checkbox"/> Exclude Completed Operations				
<input checked="" type="checkbox"/> <u>Commercial Auto Liability</u> <input type="checkbox"/> Any Auto <input type="checkbox"/> All Owned Autos <input checked="" type="checkbox"/> Scheduled Autos <input type="checkbox"/> Hired Autos <input type="checkbox"/> Non-Owned Autos <input type="checkbox"/> Drive Away <input type="checkbox"/> Specifically Described Autos	PC24112087	11/22/2024	11/22/2025	\$1,000,000 CSL \$18,500 Physical Damage-total scheduled value \$10,000 P.I.P Per Person \$10,000 U.M. Per Person \$20,000 U.M. Per Accident
<input type="checkbox"/> <u>Commercial Garage Liability</u> <input type="checkbox"/> G.K.L.L. <input type="checkbox"/> O.T.R.P.D. <input type="checkbox"/> D.O.C. <input type="checkbox"/> Cargo <input type="checkbox"/> On Hook <input type="checkbox"/> Contractual Liability Indemnification <input type="checkbox"/> Wrongful Repossession <input type="checkbox"/> Exclude Completed Operations <input type="checkbox"/> Exclude Products <input type="checkbox"/> Claims Made				
<input type="checkbox"/> <u>Excess Liability</u> <input type="checkbox"/> Claims Made				
OTHER <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>				
DESCRIPTION OF OPERATION/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>				
<input checked="" type="checkbox"/> CERTIFICATE HOLDER <input type="checkbox"/> ADDITIONAL INSURED <input type="checkbox"/> LOSS PAYEE <input type="checkbox"/> WAIVER OF SUBROGATION <input type="checkbox"/> PRIMARY AND NON-CONTRIBUTORY				
PROOF OF INSURANCE <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>		SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NO WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE <div style="border: 1px solid black; height: 40px; margin-top: 5px; position: relative;"> </div>		

State of Florida

Department of State


I certify from the records of this office that TRUCARE TRANSPORT LLC is a limited liability company organized under the laws of the State of Florida, filed on March 29, 2023.

The document number of this limited liability company is L23000156952.

I further certify that said limited liability company has paid all fees due this office through December 31, 2025, that its most recent annual report was filed on February 27, 2025, and that its status is active.

*Given under my hand and the
Great Seal of the State of Florida
at Tallahassee, the Capital, this
the Twenty-seventh day of May,
2025*




Secretary of State

Tracking Number: 2724006452CU

To authenticate this certificate, visit the following site, enter this number, and then follow the instructions displayed.

<https://services.sunbiz.org/Filings/CertificateOfStatus/CertificateAuthentication>

**Electronic Articles of Organization
For
Florida Limited Liability Company**

**L23000156952
FILED 8:00 AM
March 29, 2023
Sec. Of State
rhunt**

Article I

The name of the Limited Liability Company is:

TRUCARE TRANSPORT LLC

Article II

The street address of the principal office of the Limited Liability Company is:

2967 SUNCOAST BLEND DR
ODESSA, FL. US 33556

The mailing address of the Limited Liability Company is:

2967 SUNCOAST BLEND DR
ODESSA, FL. US 33556

Article III

The name and Florida street address of the registered agent is:

ARLIS FUENTES PEREZ
2967 SUNCOAST BLEND DR
ODESSA, FL. 33556

Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relating to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.

Registered Agent Signature: ARLIS FUENTES PEREZ

Article IV

The name and address of person(s) authorized to manage LLC:

Title: AMBR
ARLIS FUENTES PEREZ
2967 SUNCOAST BLEND DR
ODESSA, FL. 33556 US

L23000156952
FILED 8:00 AM
March 29, 2023
Sec. Of State
rhunt

Signature of member or an authorized representative

Electronic Signature: LOVETTE DOBSON

I am the member or authorized representative submitting these Articles of Organization and affirm that the facts stated herein are true. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S. I understand the requirement to file an annual report between January 1st and May 1st in the calendar year following formation of the LLC and every year thereafter to maintain "active" status.

RATES of REIMBURSEMENT

Monday – Friday, 7:00 AM – 5:00 PM

Contracted Rates
One-way Ambulatory: \$35.00 pickup plus \$5.00/mile
One-way Wheelchair: \$50.00 pickup plus \$5.00/mile
One-way Assistant: \$45.00
Unloaded Miles: \$1.50 (15 miles or more)
Bariatric Patient (between 250 - 350 lbs.): \$45.00
Bariatric Patient (between 350 – 450 lbs.): \$90.00
Wait Time: \$25.00 per 30 minutes
COVID Positive Patient: \$100 per one-way transport

Weekends & Monday – Friday, 5:01 PM – 11:00 PM

Contracted Rates
One-way Ambulatory: \$45.00 pickup plus \$6.00/mile
One-way Wheelchair: \$60.00 pickup plus \$6.00/mile
One-way Assistant: \$55.00
Unloaded Miles: \$2.50 (15 miles or more)
Bariatric Patient (between 250 - 350 lbs.): \$55.00
Bariatric Patient (between 350 – 450 lbs.): \$110.00
Wait Time: \$25.00 per 30 minutes
COVID Positive Patient: \$100 per one-way transport

Holidays & Monday – Sunday, 11:01 PM – 6:59 AM

Contracted Rates
One-way Ambulatory: \$55.00 pickup plus \$7.00/mile
One-way Wheelchair: \$70.00 pickup plus \$7.00/mile
One-way Assistant: \$60.00
Unloaded Miles: \$3.50 (15 miles or more)
Bariatric Patient (between 250 - 350 lbs.): \$65.00
Bariatric Patient (between 350 – 450 lbs.): \$130.00
Wait Time: \$25.00 per 30 minutes
COVID Positive Patient: \$100 per one-way transport

CANCELATION NOTICE: ALL No-Show arrivals or transports canceled within 30 minutes of pick-up time will incur the cost of a one-way transport.



[Department of State](#) / [Division of Corporations](#) / [Search Records](#) / [Search by Entity Name](#) /

Detail by Entity Name

Florida Limited Liability Company
TRUCARE TRANSPORT LLC

Filing Information

Document Number	L23000156952
FEI/EIN Number	35-2799382
Date Filed	03/29/2023
State	FL
Status	ACTIVE

Principal Address

15985 Preserve MarketPlace
#1018
ODESSA, FL 33556

Changed: 03/20/2024

Mailing Address

15985 Preserve MarketPlace
#1018
ODESSA, FL 33556

Changed: 03/20/2024

Registered Agent Name & Address

FUENTES PEREZ, ARLIS
2967 SUNCOAST BLEND DR
ODESSA, FL 33556

Authorized Person(s) Detail

Name & Address

Title AMBR

FUENTES PEREZ, ARLIS
2967 SUNCOAST BLEND DR
ODESSA, FL 33556

Annual Reports

Report Year	Filed Date
2024	04/30/2024

2025

02/27/2025

Document Images

[02/27/2025 -- ANNUAL REPORT](#)

View image in PDF format

[04/30/2024 -- ANNUAL REPORT](#)

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[03/29/2023 -- Florida Limited Liability](#)

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