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May 6, 2013

Via Electronic Filing

Rosemary Chiavetta, Secretary
PA Public Utility Commission
PO Box 3265
Harrisburg, PA 17105-3265

Re: Virgo Medical Services, Inc.'s Application
Docket No. A-2012--2338916

Dear Secretary Chiavetta:

Enclosed for electronic filing please find Virgo Medical Services, Inc.'s Response to the Data Requests of the Bureau of Technical Utility Services with regard to the above-referenced matter.

Sincerely,



Carl R. Shultz

CRS/lww
Enclosure

cc: Tony Agosto, Virgo Medical Services w/enc. (via email only)
Rodney D. Bender, P.E., Manager Transportation Division, TUS w/enc.
Josh Kwiatkowski, TUS w/enc. (via fax only)

**RESPONSE OF
VIRGO MEDICAL SERVICE, INC.
TO THE DATA REQUESTS OF
THE BUREAU OF TECHNICAL UTILITY SERVICES
AT DOCKET NO. A-2012-2338916**

Request 1: Please provide statements of support from residents of the City and County of Philadelphia. Generally, it is considered necessary for you to include support from at least five supporters operating/residing in each county that you intend to operate in and who will utilize your service. Said supporters should not be family members, employees, or members of employees' families of the applicant. The attached sample form may be copied and utilized to obtain statements in support of your application.

Response: Please see the attached sheets.

Response provided by: Tony Agosto, CEO, Virgo Medial Services, Inc.

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Sharon Reavis
Name of Supporter

511 W GLENDON ST PHILA PHILA PA 19120
Street Address City or Municipality County State Zip Code

VIRGO MEDICAL SERVICES
Name of Applicant

- Describe the type of transportation service needed.

Dialysis 3x week

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

Home Philadelphia to dialysis Philadelphia

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

3x week

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Sharon Reavis
(Signature)
SHARON REAVIS
(Name, printed or typed)

5-3-12
(Date)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Wendell Miller
Name of Supporter

3907 Conshohocken Ave Paha - PA 19131
Street Address City or Municipality County State Zip Code

VIRGO Medical
Name of Applicant

- Describe the type of transportation service needed.

VAN SERVICE, VETS THAT CANE CATCH PUBLIC TRANS. WHEEL CHAIR, WALKER ETC.

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

FROM MY HOME TO VA APPOINTMENTS AND BACK

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

3-4 TIMES A WEEK

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The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Wendell Miller
(Signature)
WENDELL MILLER
(Name, printed or typed)

4-30-13
(Date)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Roberta Tillman
Name of Supporter

50 Garrison Circle Willingboro Burl N.J 08046
Street Address City or Municipality County State Zip Code

Virgo medical
Name of Applicant

- Describe the type of transportation service needed.

HOSP

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

3900 Woodland Ave

VA Hospital

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

Monthly

VERIFICATION OF STATEMENT

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The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Roberta Tillman
(Signature)
Roberta Tillman
(Name, printed or typed)

4-30-13
(Date)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

James Copeland
Name of Supporter

545 N PAXON ST PHILA PA 19131
Street Address City or Municipality County State Zip Code

JAMES COPELAND VIRGO MEDICAL
Name of Applicant

- Describe the type of transportation service needed.
DIALYSIS + HOSP
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.
545 N PAXON ST PHILA 19131
1241 N TANNEY ST PHILA DIALYSIS
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?
3 TIMES A WEEK

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

James Copeland
(Signature)
JAMES COPELAND
(Name, printed or typed)

4.30.13
(Date)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Norman J. Flan

Name of Supporter

34 River DR DeFran Burlington N.J. 08075

Street Address

City or Municipality

County

State

Zip Code

VIRGO MEDICAL SERVICES

Name of Applicant

- Describe the type of transportation service needed. I need a van and a driver because I can not see my eyes are bad (cataracts) and I have problems with my back and legs
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships. my house to V.A. hospital and back home again
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis? according to what the doctors order for me once, twice five times if needed

VERIFICATION OF STATEMENT

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The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Norman J. Flan

(Signature)

NORMAN J. FLAM

(Name, printed or typed)


05-01-2013

(Date)

VERIFICATION

I, Tony Agosto state that I am the CEO for the Virgo Medial Services, Inc. and that as such I am authorized to make this verification on its behalf. I hereby state that the facts contained in the foregoing document are true and correct (or are true and correct to the best of my knowledge, information and belief) and that I expect to be able to prove the same at a hearing held in this matter. I understand that the statements herein are made subject to the penalties of 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities.

Date: May 6, 2013



Tony Agosto, CEO
Virgo Medial Services, Inc.