FIRST RESPONDER/PRIMARY SERVICE AREA PROCESS

Complete the "Combination Application for First Responder and Primary Service Area Responder" and submit it to the Office of Emergency Medical Services (OEMS).

The Office of Emergency Medical Services shall, in consultation with the appropriate Regional Council(s), review the application for completeness. It shall be the sole responsibility of OEMS to deem the application complete. Requests for additional information shall be forwarded to the applicant within thirty (30) days of the receipt of the application. The applicant shall provide such requested additional information within ten (10) working days of the receipt of such request. The Regional Council(s) shall have forty-five (45) days after the receipt of an application to forward a recommendation to OEMS. The OEMS shall render a decision on the application within ten (10) working days after the receipt of the Regional Council(s) recommendation. The above time lines may be waived by mutual agreement.

All parties shall receive written notification of the decision of the OEMS.

REQUIRED LETTERS OF ENDORSEMENT AND CERTIFICATE OF INSURANCE

Submit the original application (including all letters of endorsement) to the address below, to the attention of the Regional EMS Coordinator.
Please remember to retain a copy for your records.

Department of Public Health
Office of Emergency Medical Services
410 Capitol Avenue, MS#12EMS
PO Box 340308
Hartford, CT 06134-0308
(860) 509-7975

1. A letter from the Chief Elected Official of the town or political jurisdiction in which the First Responder service is to be provided supporting the application; and

2. A letter from the Chief Executive Officer of the EMS organization that is the designated PSAR at the Basic Life Support level, supporting the application.

3. A letter from the Chief Executive Officer of the appropriate 9-1-1 Public Safety Answering Point (PSAP) or EMS dispatch agency that supports the proposed First Responder dispatch protocols and acknowledges that the protocols will be used if the application is approved.

4. Certificate of Insurance Forms:
   - Proof showing General or Public Liability Insurance
   - Malpractice Insurance (Also known as Professional Liability)

5. A completed Initial Application for EMS Sponsor Hospital Form

COMBINATION APPLICATION FOR FIRST RESPONDER AND PRIMARY SERVICE AREA RESPONDER (PSAR) ASSIGNMENT

PROVIDER INFORMATION

1. Name of Service: _____

2. Business Address: _____

   _____

3. Mailing Address: _____

   _____

4. Telephone Numbers:
   Business - 1: _____
   Business - 2: _____
   FAX: _____
   E-Mail Address _____

5. Federal Employer Identification Number: _____

6. Chief Executive Officer:
   Name: _____
   Title: _____
   Telephone (work) _____
   Telephone (home) _____
   E-Mail Address _____

7. Contact Person
   Name: _____
   Telephone (work) _____
   Telephone (home) _____
   E-Mail Address _____

All information provided within this application is, to the best of my knowledge, true and correct.

_____ Date

_____ Chief Executive Officer

8. Type of PSAR Assignment Requested: Place a "check mark" (✓) between the appropriate parentheses to indicate your choice:

A. First Responder ☐

B. Basic Ambulance ☐

C. Mobile Intensive Care - Intermediate ☐

D. Mobile Intensive Care - Paramedic ☐

E. Aeromedical ☐

Is the PSA assigned at the First Responder level? Yes ☐ No ☐

If "yes" is checked, enter name of First Responder PSAR:

_____

Is the PSA assigned at the Basic Ambulance level? Yes ☐ No ☐

If "yes" is checked, enter name of Basic Ambulance PSAR:

_____

Is the PSA assigned at the MIC-I or MIC-P level? Yes ☐ No ☐

If "yes" is checked, enter name of MIC-I or MIC-P PSAR:

_____

9. Type and Number of vehicles to be equipped:

A. Number of transporting EMS vehicles: _____
B. Number of non-transporting EMS vehicles: _____
C. Total: _____

EFFECT OF PROPOSED ASSIGNMENT

Please provide a narrative description of how the primary service area responder service will function. Include at least the following information: 1) a description of the need for the applicant primary service area responder level of service; 2) how the applicant primary service area responder will interact and integrate with existing providers in the proposed service area; and 3) how the designation of the applicant primary service area responder will improve patient care in the Primary Service Area to be served. Attach additional pages if necessary.

Narrative:

GEOGRAPHIC COVERAGE

1. Describe, in detail, the boundaries of the geographic area which will be covered by this assignment (A MAP OF THE PROPOSED PRIMARY SERVICE AREA MUST BE INCLUDED).
2. Indicate the total population of the proposed service area.
3. List any existing mutual aid agreements with other EMS provider organizations (specify the licensure/certification level of each identified provider organization).
4. Enclose copies of any existing mutual aid agreements (or any other letters of agreement affecting the proposed service area) as part of this application.

ACTIVATION TIME

This section should include the following information:

1. Name of EMS Dispatch Agency: _____
2. Description of communications equipment that will activate EMS provider organization personnel:

3. Activation time information:

"Activation time" means the measure of time from notification to the EMS provider organization that an emergency exists, to the beginning of the response of EMS provider organization personnel. Please provide activation time data for the twelve (12) months preceding the submission of this application in the "fractile" format listed below.

Activation Time Fractile Data:

From: _____ (mo / day / yr) To: _____ (mo / day / yr) Based on ____ total responses

Percentage of Responses where activation time was:

Less than or equal to one minute	_____
Greater than one minute but less than or equal to two minutes	_____
Greater than two minutes but less than or equal to three minutes	_____
Greater than three minutes but less than or equal to four minutes	_____
Greater than four minutes	_____

If activation time data for the preceding twelve months does not exist, please describe the plan for collecting fractile activation time data on an additional narrative page.

RESPONSE TIME AND TWENTY-FOUR HOUR COVERAGE

This section should include the following information:

1. Estimated annual call volume: _____
2. Fractile Response time data:
   "Response Time" means the total measure of time from notification to the EMS provider organization that an emergency exists, to arrival at the patient's side (including the activation time). Please provide response time data for the twelve (12) months preceding the submission of this application in the "fractile" format listed below.

   From: _____ To: _____ Based on _____ total responses
   mo / day / yr mo / day / yr

   Percentage of responses that were:

   Less than or equal to four minutes _____
   Greater than four minutes but less than or equal to five minutes _____
   Greater than five minutes but less than or equal to six minutes _____
   Greater than six minutes but less than or equal to seven minutes _____
   Greater than seven minutes but less than or equal to eight minutes _____
   Greater than eight minutes _____

   If fractile response time data for the preceding twelve months does not exist, please describe the plan for collecting fractile response time data on an additional narrative page.

3. Staffing Plan - describe the staffing plan that will assure twenty-four hour per day, seven day per week coverage.

PERSONNEL ROSTER

This section should include the following information for each full-time/part-time employee/member to be utilized by the applicant:

Provider Name	Provider Level	Certification or License Number	Expiration Date
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
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	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		

VEHICLE INFORMATION

This section should include the following information for each vehicle to be utilized by the applicant (copy this page and attach for additional vehicles):

Vehicle Make: _____

Chassis/Model: _____ Year: _____

Classification: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Vehicle Make: _____

Chassis/Model: _____Year: _____

Classification: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Vehicle Make: _____

Chassis/Model: _____Year: _____

Classification: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

CERTIFICATES OF MALPRACTICE AND MEDICAL LIABILITY INSURANCE

In accordance with CGS 19a-180, the following shall be the required limits for licensure and certification:

1. For damages by reason of personal injury to, or the death of, one person on account of any accident at least five hundred thousand dollars, and more than one person on account of any accident at least one million dollars.
2. For damage to property at least fifty thousand dollars and
3. For malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars.

In lieu of the limits set forth in subdivisions 1 to 3, inclusive, of this subsection, a single limit of liability shall be followed as follows:

A. For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and
B. For malpractice in the care of one or more passengers, at least five hundred thousand dollars.

ATTACHMENTS REQUIRED:
Attach current insurance policy declarations page(s) verifying the minimum insurance requirements outlined above.

DISPATCH POLICY AND PROTOCOLS

Please describe below, or provide a copy as an attachment, approved dispatch protocols that describe chief complaints, situations or types of EMS incidents that will result in the dispatch of the first responder. In the space provided below describe the methodology for periodically reviewing (at least annually) and/or amending the first responder dispatch protocols. Note: You may attach the protocols via CD or thumb drive.

SIGNATURE PAGE

The Chief Executive Officer of each first responder service must sign this page as an express condition to operate as a first responder service.

_____
(Name of applicant service)

I do hereby warrant and certify that the above-named EMS provider organization shall carry out its responsibilities as a certified First Responder in accordance with Section 19a-179-4(a) of the Regulations of Connecticut State Agencies. Specifically, the above-named service shall provide at least the following at the scene of each EMS call to which it responds:

1. One Medical Response Technician (EMR) who is certified in accordance with section 129a-179-16(a) of the Regulations of Connecticut State Agencies.
2. A two-way radio compatible with the First Responder dispatcher.
3. Bandaging material and dressings sufficient to control hemorrhage.
4. Oropharyngeal or mouth-to-mouth airways in infant, child and adult sizes. Such airways shall be non-rigid and non-metal in construction.
5. Portable oxygen administration apparatus with a thirty (30) minutes supply of oxygen (at seven (7) liters per minute flow rate), which is operable totally detached from the parent vehicle. Such oxygen administration unit shall be capable of accepting attachment to a nasal canal, mouth/nose oxygen mask or as enrichment feed to a forced ventilation unit.

And, all First Responder vehicles listed in the Vehicle Information section of this application shall be equipped in compliance with the equipment standards published annually by the Commissioner pursuant to CGS 19a-177. The most current standard can be found on the Communications & References Documents page of the OEMS website.

_____ _____
Date Chief Executive Officer

INITIAL APPLICATION FOR EMS SPONSOR HOSPITAL

1. Name of EMS Organization: _____

2. Mailing Address: _____

   Phone: _____ Fax: _____

3. Name of Chief/CEO and Title: _____

4. Chief/CEO Phone: _____Email: _____

I understand and agree that the skill(s) for which we are authorized is contingent upon sponsor hospital medical control and compliance with Section 19a-179-12 of the Regulations which govern the delivery of prehospital emergency medical services.

_____ _____

Chief/CEO Signature Date

5. At what level is your organization licensed/certified or authorized? *(check all that apply)*

Supplemental First Responder ☐ First Responder ☐ Basic Ambulance ☐

AEMT ☐ Paramedic ☐

6. What BLS skills is your organization authorized to perform? *(circle all appropriately)*

AED (EMR and above)	Yes ☐	No ☐
Aspirin (EMT and above)	Yes ☐	No ☐
Continuous Positive Airway Pressure (CPAP) (EMT and above)	Yes ☐	No ☐
Glucometer (EMT and above)	Yes ☐	No ☐
Epinephrine Auto injector (EMT and above)	Yes ☐	No ☐
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and above)	Yes ☐	No ☐
Twelve Lead ECG Acquisition and Transmission (EMT and above)	Yes ☐	No ☐

Sponsor Hospital Information

Name of Sponsor Hospital: _____

Address: _____

EMS Medical Director_____ Phone: _____

E-mail: _____ Fax: _____

EMS Coordinator: _____ Phone: _____

E-mail: _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

The above provider has complied with all conditions as set forth by this sponsor hospital for Mobile Intensive Care and/or BLS skill authorization, but not limited to, initial provider training. Therefore, on behalf of the Sponsor Hospital we agree to provide medical control in accordance with Section 19a-179-12)(a) of the Regulations of Connecticut State Agencies which govern the delivery of pre-hospital emergency medical services.

_____ _____

Medical Director Print Signature Date

_____ _____

EMS Coordinator Print Signature Date

SHADED AREA FOR OEMS USE ONLY

OEMS Approval Date: _____

Notice sent to **Service and Hospital** ❑ Yes ❑ No Date: _____

Signature: _____ Date: _____