STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

MOBILE INTENSIVE CARE UPGRADE APPLICATION

INSTRUCTIONS

This application is to be completed fully by the applicant. Please do not leave required fields blank, enter "N/A" if it does not apply. You are strongly encouraged to contact your Regional EMS Coordinator for any assistance you may require in completing this application. Please review Connecticut General Statutes and Regulations of Connecticut State Agencies governing Mobile Intensive Care Service prior to completing this application.

The Office of Emergency Medical Services (OEMS) shall review the application for completeness. It shall be the sole responsibility of the 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) business days of the receipt of such request.

Once deemed complete by OEMS, the application will be forwarded to the affected Regional Council(s) for review and recommendation. The Regional Council(s) shall have forty (40) days after receipt of the application to forward a recommendation to the OEMS. The OEMS shall render a decision on the application within ten (10) business days after receipt of the Regional Council(s) recommendation.

NOTE: Local EMS Planning is the responsibility of the municipality. Any affected municipality should be included in discussions regarding modifying EMS resource deployment or system design.

The following must be included in your application submission:

1. This completed application;
2. A letter of support from the municipal chief elected official in which the applicant is requesting;
3. A list of currently certified personnel trained to the new level of authorization;
4. A copy of the clinical care protocols for this new level of authorization (electronic copy is acceptable);
5. A copy of the sponsor hospital quality assurance plan for this new level of authorization;
6. A list of EMS organizations you currently have written mutual aid agreements that will assist in providing uninterrupted 24/7/365 coverage at the requested level.

Submit the original application (including all required attachments) 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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

MOBILE INTENSIVE CARE UPGRADE APPLICATION

PROVIDER INFORMATION

Legal Name of Service: _____

Business Address: _____

_____

Person completing this form: _____

Title: _____

Primary Telephone: _____ Secondary Telephone: _____

Email: _____

CURRENT LEVEL OF CERTIFICATION/LICENSE (check all that apply):

Check what level of service you currently hold:	
First Responder	☐
Basic Ambulance	☐
Mobile Intensive Care - Advanced	☐
Mobile Intensive Care - Paramedic	☐

LEVEL *REQUESTING*

Check level of authorization your organization is requesting (check all that apply)	Is there a PSAR currently assigned at that level?	If "yes" enter name of PSAR
Basic Ambulance ☐	☐ YES ☐ NO	
Mobile Intensive Care – Advanced ☐	☐ YES ☐ NO	
Mobile Intensive Care - Paramedic ☐	☐ YES ☐ NO	

How will you schedule the members of your organization who are trained at this new level to assure 24-hour coverage? Provide narrative (use extra sheets if needed).

FOR OFFICE OF EMS USE ONLY

FOR OEMS USE ONLY	
DATE RCVD:	RC REVIEW COMPLETE:
DEEMED COMPLETE DATE:	OEMS DIRECTOR SIGNATURE

ATTACHMENTS (REQUIRED)

All attachments must be clearly numbered and referenced.

Example: "See ATTACHMENT 1 – MUNICIPAL LETTER OF SUPPORT"

☐ **ATTACHMENT 1 – MUNICIPAL LETTER OF SUPPORT.**
A letter of support from the municipal CEO supporting the application.

☐ **ATTACHMENT 2 – ROSTER OF CURRENTLY CERTIFIED/LICENSED PERSONNEL.**
List should include first/last name, certification/license number and expiration date for each person trained to the requested level.

☐ **ATTACHMENT 3 – COPY OF THE SPONSOR HOSPITAL CLINICAL CARE PROTOCOLS.**
An electronic copy is acceptable.

☐ **ATTACHMENT 4 – COPY OF THE SPONSOR HOSPITAL QUALITY ASSURANCE PLAN FOR THE REQUESTED LEVEL.**
An electronic copy is acceptable.

☐ **ATTACHMENT 5 – LIST OF MUTUAL AID AGREEMENTS.**
All EMS organizations you currently have written mutual aid agreements with (copies of the agreements are acceptable).

SPONSOR HOSPITAL INFORMATION AND TREATMENT PROTOCOLS

Name of Sponsor Hospital:_____
Address: _____
Medical Director: _____ Phone: _____

E-Mail: _____ Fax: _____

EMS Clinical Coordinator: _____ Phone: _____
E-Mail: _____ Fax: _____

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

Title of Sponsor Hospital Protocols: _____
Revision Date: _____

Have the Protocols been made available to the authorized staff members of you organization? ☐ Yes ☐ No

SPONSOR HOSPITAL AGREEMENT

We, the undersigned acknowledge the information within this application has been reviewed in its entirety, and collectively, we agree to sponsor the applicant at the requested level of care. We accept the responsibilities described in Regulations of Connecticut State Agencies section 19a-179-12 regarding Mobile Intensive Care Services.

_____	_____	_____
Sponsor Hospital EMS Clinical Coordinator (print)	**Signature**	**Date**
_____	_____	_____
Sponsor Hospital EMS Medical Director (print)	**Signature**	**Date**
_____	_____	_____
Sponsor Hospital CEO (print)	**Signature**	**Date**

SIGNATURE PAGE FOR CHIEF EXECUTIVE OFFICER OR OTHER AUTHORIZED AGENT

I, the undersigned, acknowledge that the information provided within this application is current and accurate. I understand and agree that the approval of this upgrade is contingent upon the continuance of medical direction and compliance with the Connecticut General Statutes and Regulations of Connecticut State Agencies governing the delivery of emergency medical services.

Name (print)	**Signature**
Title	**Date**

Click to print