PRIMARY SERVICE AREA RESPONDER APPLICATION

This application is to be completed fully by the applicant. You are strongly encouraged to contact your Regional EMS Coordinator for any assistance you may require in completing this application.

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

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 the Office of Emergency Medical Services 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. The Regional Council(s) shall have forty-five (45) days after receipt of an application to forward a recommendation to the Office of Emergency Medical Services. The Office of Emergency Medical Services shall render a decision on the application within ten (10) business days after receipt of the Regional Council(s) recommendation. The above time lines may be waived by mutual agreement.

REQUIRED ATTACHMENTS

A letter of support from the Chief Elected Official of the municipality in which the PSA lies.

A letter of support from the Chief Executive Officer of the EMS Organization in which the PSA lies.

Certificate of Insurance Forms:

- Proof showing General or Public Liability Insurance
- Malpractice Insurance (also known as Professional Liability)

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

APPLICATION FOR PRIMARY SERVICE AREA RESPONDER (PSAR) ASSIGNMENT

PROVIDER INFORMATION

1. **Name of Service:** _____

2. **Street Address:** _____

   _____

3. **Mailing Address:** _____

   _____

4. **Telephone Numbers:** **Business:** _____

   Emergency: _____

   FAX: _____

5. **Chief Executive Officer:** **Name:** _____

   Title: _____

   Telephone _____

6. **Contact Person** **Name** _____

   Title: _____

   Telephone: _____

   E-Mail Address _____

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

FOR OEMS USE ONLY		
APP NUMBER:	REVIEWED BY:	DATE REVIEW COMPLETE:
DIRECTOR SIGNATURE:		DATE DIRECTOR DEEMED COMPLETE:

APPLICATION FOR PRIMARY SERVICE AREA RESPONDER (PSAR) ASSIGNMENT

PROVIDER INFORMATION (CON'T)

7. Type of PSAR Assignment Requested (select all that apply):

First Responder ☐
Basic Ambulance ☐
Mobile Intensive Care – Advanced ☐
Mobile Intensive Care - Paramedic ☐

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-A or MIC-P level? yes ○ no ○

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

_____

8. Type and Number of vehicles to be equipped:

Number of transporting EMS vehicles:
Number of non-transporting EMS vehicles:
Total:

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

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 as primary service area responder will improve patient care in the Primary Service Area to be served. Attach additional pages if necessary.

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

GEOGRAPHIC COVERAGE

1. Describe, in detail, the boundaries of the geographic area that will be covered by this assignment (A MAP OF THE PROPOSED PRIMARY SERVICE AREA MUST BE INCLUDED AS AN ATTACHMENT).

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). Enclose copies of any existing mutual aid agreements (or any other letters of agreement affecting the proposed service area) as part of this application.

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

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

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: _____%
Total: _____%

4. If activation time data for the preceding twelve months does not exist, please describe the plan for collecting fractile activation time data (attach additional page if necessary).

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

RESPONSE TIME AND TWENTY-FOUR HOUR COVERAGE

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 response times 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: _____%
   Total: _____%

3. Staffing Plan - describe the staffing plan that will assure 24/7/365 basis.

4. If 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.

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

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	Provder Level	Certification or License Number	Expiration Date
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
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	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		
	CHOOSE		

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

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:_____Year:_____

Classification:_____

Vehicle ID Number (VIN):_____

Marker Number:_____

_____

Vehicle Make:_____

Chassis:_____Year:_____

Classification:_____

Vehicle ID Number (VIN):_____

Marker Number:_____

_____

Vehicle Make:_____

Chassis:_____Year:_____

Classification:_____

Vehicle ID Number (VIN):_____

Marker Number:_____

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

CHIEF ADMINISTRATIVE OFFICIAL'S RECOMMENDATION

Section 19a-179-4 (b) of the Regulations of Connecticut State Agencies states that prior to the assignment of a Primary Service Area, OEMS shall solicit the advice and recommendation of the appropriate regional council and the chief administrative official of the municipality in which the PSAR lies.

The chief administrative official (or officials) of the municipality (or municipalities) in which the proposed primary service area lies should complete this page of the application.

NAME (please print):_____

TITLE:_____

MUNICIPALITY: _____

I recommend that OEMS:
approve ◯
not approve ◯
this application for Primary Service Area Responder designation.

SIGNATURE: _____ DATE: _____

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

SIGNATURE PAGE

The Chief Executive Officer of the proposed service must read and sign this page.

_____
Name of applicant service

I do hereby warrant and certify that the above-named EMS provider organization shall carry out its responsibilities in accordance with Section 19a-179-4(a) of the Regulations of Connecticut State Agencies.
All information provided within this application is, to the best of my knowledge, true and correct.

_____ _____
Chief Executive Officer Date

To Print

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.