NEED FOR NEW OR EXPANDED SERVICES APPLICATION

The following documents are attached:

1. Instructions for Filing the Application
2. Need for New or Expanded Services Application

Please note Section **19a-180-6 - Case in Support** of the attached Need for Service Regulations. Once the Office of Emergency Medical Services has deemed your application complete, it is considered to be the case in support of the need for a new or expanded EMS service. All information you want to present must be submitted with the application package. Your application, and all supporting documentation, will be forwarded to the affected Regional EMS Council(s) for review and recommendation. The Regional Council's recommendation is forwarded to the Office of Emergency Medical Services. A public hearing is scheduled to receive further testimony regarding your application. At the public hearing, applicants may not present any new information. However, testimony in support of the evidence already submitted may be heard. The Department of Public Health's decision on the application shall be based on:

1. **The completed application and supporting documentation.**
2. **The recommendation of the Regional Council(s).**
3. **Any additional information or testimony provided by any person pertaining to the application.**

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

INSTRUCTIONS FOR FILING
NEED FOR NEW OR EXPANDED SERVICES APPLICATION

NOTE:
This form *must* be used.
Do not leave any sections blank.
If a certain section is not applicable, enter "N/A".

CORPORATE INFORMATION

A. Enter the **corporate name** as filed with the Secretary of State and as listed on the Articles of Incorporation. If the service is a non-incorporated business, list the responsible party by name on this line. Attach a copy of the Certificate of Need or License of Operation to this application.

B. The **street address** must be shown for the headquarters or corporate offices. This should clearly indicate the location from where the service will be administered.
The **mailing address** must be entered if it is different from the street address. (Include post office box numbers, post office drawers, or other identifiers to where mail is received.)
List the **business telephone** for the service headquarters, including the area code.
The number entered should be the "non-emergency" telephone number used by the service for business or administrative purposes.
List the **fax number** and include the **e-mail address** of your organization.
The **name and title of the person responsible for completing the application** is entered in this section as well as the **mailing address, telephone number, fax number and e-mail address.**

C. The **trade name** is the name by which the service will be known. If the service will be known by a name other than the corporate name, that name shall be entered on this line.
All **corporate officers and their address**, regardless of their ownership in the corporation, must be listed in this section.
The **names of all persons or entities that own more than ten percent (10%) of the corporation's stock** must be listed in this section.

D. If the company is a subsidiary of another corporate structure, or if the corporation owns other companies, either in whole or in part, these companies, **parent and associated companies**, must be identified in Section "D".

TYPE OF APPLICATION

E.1. Place a "check mark" to indicate whether this application is for a **new EMS service** not currently licensed or certified in the state of Connecticut, an **expansion of an existing service**, or a **request to charge only.**

E.2. Identify the **current level of service you are authorized to provide.**

E.3. Identify the **new level of service you are requesting.**

E.4. **Provide a summary rationale for your request**.

E.5. **Proposed location of headquarters offices and branch locations.**

F. Identify **existing licensed or certified EMS provider organizations operating within the proposed service area**.

G. Identify **all primary-receiving facilities within the proposed service area including long term care facilities**. If no primary receiving facilities exist within the proposed service area identify the closest primary receiving facility. ***(add additional pages as necessary)***

The **total number of beds** within the facilities identified in Section "G" shall be entered in this section. This information may be obtained from the Department of Public Health's Bureau of Regulatory Services or by contacting the facilities directly.

DEMOGRAPHIC/GEOGRAPHIC INFORMATION

H. List the **Geographic Area(s) to be Served**.

I. Identify the **Population Estimate** to be served.

J. **List the Boundaries of the Service Area** - Boundaries may be identified by geopolitical borders (cities, towns, fire districts) or by street names or route numbers. When street names or route numbers are used they should identify the northern, eastern, southern, and western borders of any proposed service area. This information is intended to identify the major service area proposed by the applicant. It is not intended to be a description of an "exclusive service area" which limits the applicant service to responses within that area. ***(Include required map attachment)***

K. Identify the **Number of Projected Calls** to which you will respond - The total number of projected calls the applicant service will respond to in the proposed service area, during the twelve (12) months following the month in which the application is submitted, shall be entered in this section.

L. List the **Source and Total Number of Projected Responses in the proposed service area.**

M. **Identify the EMS Regions Affected.**

EXISTING SERVICE HISTORICAL DATA

N. The **source and total number of all requests** for service responded to by the applicant service during the twelve months preceding the submission of the application shall be entered in this section. **An applicant for a new EMS service that has not accumulated any historical service data may skip this section**.

O. The **total number of requests for service** which were refused during the twelve months preceding the submission of the application shall be entered in this section. An explanation of the major reason(s) for refusal of requests for service shall also be entered in this section. **An applicant for a new EMS service that has not accumulated any historical service data may skip this section**.

P. **Source and Total Number of Calls** expected over the next twelve (12) months shall be entered in this section.

Q. **Average Response Times** (Fractile) The fractile response times for the twelve (12) months preceding the submission shall be entered in this section. "Response Time" is defined as the total measure of time from notification to the EMS provider organization that and emergency exists, to the arrival at the patient's side (including the activation time). NOTE: An applicant for a new EMS service that has not accumulated any historical service data may skip this section**.**

ATTACHMENTS (REQUIRED)

The attachments listed on page 6 of the application **must** accompany the application form. All attachments must be clearly titled/labeled and referenced in the application (i.e. See Attachment 1- Evidence of Paid in Working Capital, See Attachment 2- Regional Geographical Map, etc). The attachments are considered to be part of the application. The application will be considered incomplete if the listed attachments are not included or labeled.

1. The applicant shall provide **evidence of paid-in working capital OR** a binding credit agreement sufficient to operate all resources requested in the application for a period of six months.
   Explanation:
   In order to satisfy this section of the application, calculate the amount that it will cost the applicant service to operate all of the resource authorities being requested for a period of six months.
   Example:
   If the projected total cost (personnel salaries, lease, fuel, maintenance, etc.) of operating one additional requested vehicle authority for one month is$7,000.00, the projected six-month operating cost is $42,000.00 ($7,000 x 6 months = $42,000).
   Therefore, the applicant must provide documentation from a bank or other bona fide financial institution that it has 1) paid-in working capital of $42,000.00; or 2) a binding credit agreement in the amount of $42,000.00; or 3) proof of cash on hand in the amount of $42,000.00.
2. **Analysis of how the new or expanded service(s) will integrate with the current emergency medical services system**.
3. Provide an **analysis of the improvement in cost effectiveness** to the provider as a direct result of the proposed service.
4. **Proof of insurance or letter of intent** for new services at levels required by Section 19a-180-2(d) of these regulations; and Certificate of Operation.
5. A description of the **methodology used to determine the projected number of calls** listed in Section "k" of this application.
6. **Regional/Geographic map of the proposed service.**
7. **Proof of existing EMS License or Certificate of Operation** if applicable.
8. **Letter of support** from Chief Elected Official in affected municipality(ies).
9. **For new services only** - Provide a fully executed Initial Application for EMS Sponsor Hospital.
10. Any **other information** may be included by the applicant.

NEED FOR NEW OR EXPANDED EMS SERVICES APPLICATION

CORPORATE INFORMATION

A. Corporation Name: _____

B. Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address (If different from above): _____

City: _____ **State**_____ **Zip:** _____

Business Phone: _____

Fax Number: _____

Email Address: _____

Application Completed By:

Name: _____ **Title:** _____
Address:_____
City: _____ **State:** _____ **Zip:** _____

Business Phone: _____
Fax Number: _____
Email Address: _____

C. Trade Name: _____

Corporate Officers

Name: _____
Address: _____
Any additional corporate officers, who own more than 10% of the corporation's stock, must be listed in this section. (additional pages may be included if needed)

_____
_____
_____

D. Parent & Associated Companies:

_____
_____
_____

FOR OFFICE OF EMS USE ONLY

NUMBER:	**DATE RECEIVED:**	**DATE REVIEWED BY REG. COORDINATOR:**
DATE DEEMED COMPLETE:		**INITIALS:**

TYPE OF APPLICATION

E.1 **What type of service are you requesting?**

- ☐ **New Service**
- ☐ **Expansion of Existing Service**
- ☐ **Request to Charge**

E.2 **What services are you *currently authorized* to provide? (Check all that apply):**

- ☐ **First Responder** — **# of authorized vehicles: _____**
- ☐ **Ambulance** — **# of authorized vehicles: _____**
- ☐ **Non-transport– Advanced** — **# of authorized vehicles: _____**
- ☐ **Non-transport – Paramedic** — **# of authorized vehicles: _____**
- ☐ **Invalid Coach** — **# of authorized vehicles: _____**
- ☐ **Air Ambulance** — **# of aircraft: _____**

E.3 **What services are you *requesting authorization* to provide? (Check all that apply):**

- ☐ **Principal place of business**
- ☐ **Additional Branch place of business(es)** — **# requested: _____**
- ☐ **Additional Ambulance(s)** — **# requested: _____**
- ☐ **First Responder** — **# requested: _____**
- ☐ **Ambulance** — **# requested: _____**
- ☐ **Non-transport - Advanced** — **# requested: _____**
- ☐ **Non-transport - Paramedic** — **# requested: _____**
- ☐ **Invalid Coach** — **# requested: _____**
- ☐ **Additional Invalid Coach(es)** — **# requested: _____**
- ☐ **Air Ambulance(s)** — **# requested: _____**

E.4 **Provide a summary rationale for requesting this new level of service including, if appropriate, a rationale for the request to charge for service. (Please use statistics and other data to support your rationale and attach additional pages as needed.)**

E.5 Proposed Location of Headquarters' Offices and Branch Locations:

_____
_____
_____

F. Existing Licensed or Certified PSA holders, or EMS provider organizations with principal or branch locations within the Proposed Service Area. (Use additional sheets if necessary and attach).

_____
_____
_____

G. Location of all primary-receiving facilities within the proposed service area shall be described in this section to include, but not limited, to Long Term Care Facilities. (Use additional sheets if necessary and attach.)

Name of Facility	**Town**	**Number of Beds**
_____	_____	_____
Name of Facility	**Town**	**Number of Beds**
_____	_____	_____
Name of Facility	**Town**	**Number of Beds**
_____	_____	_____
Name of Facility	**Town**	**Number of Beds**
_____	_____	_____

DEMOGRAPHIC/GEOGRAPHIC INFORMATION

H. Geographic Area(s) to be served in implementing the Proposed Service:

_____
_____
_____

I. Population Estimates to be served in implementing the Proposed Service:

_____
_____
_____

J. List Boundaries of Proposed Service Area (To be outlined on map):

_____
_____
_____

K. Total Number of Projected Calls the applicant service will respond to:_____

L. The Source and Total Number of Projected Responses in Proposed Service Area:
Total number of projected responses: _____ Source: _____

M. Identify EMS Regions Affected:

☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

EXISTING SERVICE HISTORICAL DATA

N. Source and total number of all requests for service received by over the past 12 months for a currently licensed/certified applicant:

Direct from Public through 7-digit phone number: _____
Indirect from Public through 9-1-1: _____
Direct from Health Facilities through 7-digit phone numbers: _____
Other Sources: _____

O. Total Number of requests for service (refused by) applicant over the past 12 months and the circumstances for refusal:

_____
_____
_____

Major Reason(s) for Refusal of Requests for Service (attach additional sheets if necessary):

_____
_____
_____

P. Source and total number of calls expected over the next 12 months.

_____
_____
_____

Q. Average Response Times (Fractile) over the past 12 months for a currently license applicant.

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 response time data for the preceding twelve months does not exist, please describe your plan for collecting fractile response time data. (attach and clearly label additional sheet if necessary)

_____
_____
_____
_____
_____
_____
_____

ATTACHMENTS (REQUIRED)

All attachments must be clearly numbered and referenced.
Example: "See ATTACHMENT 1 – EVIDENCE OF PAID-IN WORKING CAPITAL."

- ☐ **ATTACHMENT 1 – EVIDENCE OF PAID-IN WORKING CAPITAL.**
  Provide evidence of paid-in working capital or binding credit agreement which equals a combined total of six months operating expenses. Please provide a worksheet similar to the one in the instructions.
- ☐ **ATTACHMENT 2 – ANALYSIS OF PROPOSED SERVICE'S INTEGRATION WITH CURRENT EMS.**
  Provide an analysis of how the proposed service will integrate with the current Emergency Medical Services system.
- ☐ **ATTACHMENT 3 – ANALYSIS OF IMPROVEMENT OF COST EFFECTIVENESS.**
  Provide an analysis of the improvement in cost effectiveness to the provider as a direct result of the proposed service.
- ☐ **ATTACHMENT 4 – PROOF OF INSURANCES OR LETTER OF INTENT.**
  Provide Proof of Insurances or letter of intent for new services. Insurance must include professional liability.
- ☐ **ATTACHMENT 5 – PROJECTED NUMBER OF CALLS METHODOLOGY.**
  Description of methodology used to determine projected number of calls listed in section "K".
- ☐ **ATTACHMENT 6 – MAP OF PROPOSED SERVICE AREA.**
  Provide a regional/geographical Map of Proposed Service Area.
- ☐ **ATTACHMENT 7 – CURRENT LICENSE OR CERTIFICATE OF OPERATION.**
  Proof of existing EMS certificate or license of operation, if applicable.
- ☐ **ATTACHMENT 8 - MUNICIPAL LETTER OF SUPPORT.**
  A letter of support from the municipal CEO supporting the application.
- ☐ **ATTACHMENT 9 - For New Services only** - Provide a fully executed Initial Application for EMS Sponsor Hospital.
- ☐ **ATTACHMENT 10** - Any other information to be included by the Applicant.

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

TO BE COMPLETED BY SPONSOR HOSPITAL

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).

5. At what level is the above organization licensed/certified or authorized?

Certified ☐ Licensed ☐

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

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 ☐

7. Are you utilizing the current statewide EMS Protocols? Yes ☐ No ☐

If applicable please identify any additional protocols you are utilizing in addition to the Statewide EMS Protocols _____

_____

If no, please indicate what protocols you are using: _____

_____

The above EMS Organization has complied with all conditions as set forth by this sponsor hospital for the requested level of care, 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 of the Regulations of Connecticut State Agencies which govern the delivery of pre-hospital emergency medical services.

Medical Director Print	Signature	Date
EMS Coordinator	Signature	Date

SIGNATURE PAGE FOR CHIEF EXECUTIVE OFFICER OR OTHER AUTHORIZED AGENT

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.

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

Need for New or Expanded Services Application

STATE OF CONNECTICUT)
) **ss: County of:_____)**

Signed and sworn to, before me, this ____day of _____, 20___.

My commission Expires:_____

Commissioner of the Superior Court, Notary Public or Justice of the Peace