



# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

## APPLICATION FOR PRIMARY SERVICE AREA RESPONDER (PSAR) ASSIGNMENT

### PROVIDER INFORMATION

1. Name of Service: \_\_\_\_\_

2. Street Address: \_\_\_\_\_

\_\_\_\_\_

3. Mailing Address: \_\_\_\_\_

\_\_\_\_\_

4. Telephone Numbers: Business: (860) \_\_\_\_ - \_\_\_\_

Emergency: (860) \_\_\_\_ - \_\_\_\_

FAX: (860) \_\_\_\_ - \_\_\_\_

5. Chief Executive Officer: Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone (work) (860) \_\_\_\_ - \_\_\_\_

Telephone (home) (860) \_\_\_\_ - \_\_\_\_

6. Contact Person Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone (work) (860) \_\_\_\_ - \_\_\_\_

Telephone (hone) (860) \_\_\_\_ - \_\_\_\_

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

\_\_\_\_\_  
Chief Executive Officer

Rev: 11/02/99



Phone: (860) 509-7400

Telephone Device for the Deaf (860) 509-7191

410 Capitol Avenue - MS # 12EMS

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

**Application for PSAR Assignment**  
**Page 2 of 9**

7. **Type of PSAR Assignment Requested:** Place a “check mark” (✓) between the appropriate parenthesis 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:**

\_\_\_\_\_

8. **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:**

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**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.
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**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  
day/mo./yr. day/mo./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** \_\_\_\_\_

**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  
day/mo./yr. day/mo./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:**

<b>Name</b>	<b>Cert. Level</b>	<b>Cert. Number</b>	<b>Exp. Date</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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:** \_\_\_\_\_

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**Vehicle Make:** \_\_\_\_\_

**Chassis:** \_\_\_\_\_ **Year:** \_\_\_\_\_

**Classification:** \_\_\_\_\_

**Vehicle ID Number (VIN):** \_\_\_\_\_

**Marker Number:** \_\_\_\_\_

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**Vehicle Make:** \_\_\_\_\_

**Chassis:** \_\_\_\_\_ **Year:** \_\_\_\_\_

**Classification:** \_\_\_\_\_

**Vehicle ID Number (VIN):** \_\_\_\_\_

**Marker Number:** \_\_\_\_\_

*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. Place a “check mark” (✓) between the appropriate parenthesis to indicate your recommendation:**

**NAME (please print):** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**MUNICIPALITY:** \_\_\_\_\_

**I recommend that OEMS approve ( ) disapprove ( ) this application for Primary Service Area Responder designation.**

**SIGNATURE:** \_\_\_\_\_

**NAME (please print):** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**MUNICIPALITY:** \_\_\_\_\_

**I recommend that OEMS approve ( ) disapprove ( ) this application for Primary Service Area Responder designation.**

**SIGNATURE:** \_\_\_\_\_

**NAME (please print):** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**MUNICIPALITY:** \_\_\_\_\_

**I recommend that OEMS approve ( ) disapprove ( ) this application for Primary Service Area Responder designation.**

**SIGNATURE:** \_\_\_\_\_

**Date** \_\_\_\_\_

revised 11/2/99