

TO: Need for Service Applicant

FROM: Department of Public Health, Office of Emergency Medical Services

SUBJECT: 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
3. Regulations of Connecticut State Agencies Section 19a-180-1 through 19a180-10 - Need for Service

Please note **Section 19a-180-6 - Case in Support** of the attached Need for Service Regulations. Once your application has been deemed complete by the Office of Emergency Medical Services, 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**

Please submit the application to the CT Department of Public Health, Office of Emergency Medical Services, MS # 12 EMS, P.O. Box 340308, Hartford, CT 06134-0308, Attention: Jay Nowakowski. If you have any questions regarding the application, please contact the Office of Emergency Medical Services at (860) 509-7829.

## INSTRUCTIONS FOR FILING

### **NEED FOR NEW OR EXPANDED SERVICES APPLICATION**

#### 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 seven-digit telephone number shown in the local telephone directory(s) as the “emergency” telephone number, if applicable.

The name of the person responsible for completing the application is entered in this section.

The title of the person completing the application is entered in this section. This may be a corporate title or a business title.

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 listed in Section 1.1, that name shall be entered on this line.

All corporate officers, regardless of their ownership in the corporation, must be listed in this section.

The names of all persons or entities who 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 must be identified in Section “d”.

## **TYPE OF APPLICATION**

- e. Place a “check mark” (✓) between the appropriate brackets to indicate whether this application is for expansion of an existing service or is an application for a new EMS service not currently licensed or certified in the State of Connecticut.

Place a “check mark” (✓) between the appropriate brackets to indicate the level of EMS service that the applicant is seeking to provide.

Place a “check mark” (✓) between any of the appropriate brackets to indicate the specific authorization(s) for which you are applying.

- f. All existing licensed or certified EMS provider organizations operating within the proposed service area shall be identified in this section (including invalid coach providers).

- g. 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. If no primary receiving facilities exist within the proposed service area identify the closest primary receiving facility.

All long term care facilities (including nursing homes, convalescent homes, skilled nursing facilities, etc.) within the proposed service area shall be identified in this section.

The total number of long-term care 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.

- h. The number and type of EMS vehicles for which the applicant service is currently authorized shall be entered in this section. **An applicant for a new EMS service that does not have current authorization for any EMS vehicles may skip this section.**

All existing authorized branch locations shall be identified in this section. **An applicant for a new EMS service that does not have current authorization for any branch location(s) may skip this section.**

## **AUTHORIZATIONS REQUESTED**

- i. All EMS resource authorizations being requested by the applicant shall be identified in this section. If this application seeks authorization to provide more than one number and type of Emergency Medical Service Vehicle, the resource authorizations (i.e. ambulances, invalid coaches, branch locations) for each distinct type of Emergency Medical Service Vehicle

category shall be identified. The projected locations of headquarters offices and branch locations shall be entered in this section.

### **DEMOGRAPHIC/GEOGRAPHIC INFORMATION**

- j. The boundaries of the proposed service area shall be described in this section. 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. Please list EMS regions affected.
1. Population estimates for the proposed service area shall be taken from the most recent census figures and may be rounded to the nearest thousandth.
  2. 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.

### **EXISTING SERVICE HISTORICAL DATA**

- k. 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.**
- l. 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.**
- m. Source and volume of calls expected over the next twelve- (12) months shall be entered in this section.
- n. Fractile response times for the twelve- (12) months preceding the submission 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.

### **ATTACHMENTS**

The attachments listed below **must** accompany the application form. The attachments are considered to be part of the application. The application will be considered incomplete if the listed attachments are not included.

A description of the methodology used to determine the projected number of calls listed in Section “k” of this application.

- o. 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 (6x7=42). \$7,000*

$$\begin{array}{r} \underline{\quad\quad} \times 6 \\ \$42,000 \end{array}$$

*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.*

- p. Analysis of how the new or expanded service(s) will integrate with the current emergency medical services system. Attach copy of prior and current years budget.
- q. Provide an analysis of the improvement in cost effectiveness to the provider as a direct result of the proposed service.
- r. 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.
- s. Any other information may be included by the applicant.

NEED FOR SERVICE – CHECK LIST

The Legal Office has asked that the following materials need to be submitted with the Need for Service Application. Thank you.

- Evidence of paid-in working capital or a binding credit agreement
- Analysis of Improvement in Cost Effectiveness.
- Detailed analysis of how proposed new or expanded services will integrate with current EMS system.
- Proof of Insurance current or letter of intent for new services
- Fractile Response Times
- Hi-Lite Regional/Geographical Map to Include PSA
- Signature Page with required date and seal

Department of Public Health  
Office of Emergency Medical Services  
410 Capitol Avenue – MS # 12 EMS  
P.O. Box 340308  
Hartford, CT 06134-0308

**NEED FOR NEW OR EXPANDED SERVICES APPLICATION**

**CORPORATE INFORMATION**

**Attach a copy of the Certificate of Need or License of Operation**

a. **Corporation Name:** \_\_\_\_\_

b. **Street Address:** \_\_\_\_\_

\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
**(If different)**

\_\_\_\_\_

\_\_\_\_\_

**Business Phone:** \_\_\_\_\_

**Emergency Tel. No.** \_\_\_\_\_  
**(If applicable):**

**Application Completed By:**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

**City and State:** \_\_\_\_\_

**Business Phone:** ( ) \_\_\_\_\_ - \_\_\_\_\_

c. **Trade Name:** \_\_\_\_\_

**Corporate Officers**

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

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

If any additional corporate officers, who own more than 10% of the corporation's stock much be listed in this section using a separate sheet and the same format.

**d. Parent & Associated Companies:**

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**FOR OFFICE OF EMS USE ONLY**

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| APPLICATION NUMBER | DATE RECEIVED | DATE REVIEWED WITH REG. COORD. | DATE DEEMED COMPLETE | INITIALS |
|--------------------|---------------|--------------------------------|----------------------|----------|
|--------------------|---------------|--------------------------------|----------------------|----------|



**h. Number and Types of Currently Authorized Vehicles:**

- |                          |                                   |               |
|--------------------------|-----------------------------------|---------------|
| <input type="checkbox"/> | Ambulance(s)                      | Number: _____ |
| <input type="checkbox"/> | EMS Vehicle(s) (non-transporting) | Number: _____ |
| <input type="checkbox"/> | Invalid Coach(es)                 | Number: _____ |
| <input type="checkbox"/> | Air Ambulance(s) - Fixed Wing     | Number: _____ |
| <input type="checkbox"/> | Air Ambulance(s) – Helicopter     | Number: _____ |
| <input type="checkbox"/> | EMS Water Craft                   | Number: _____ |

**Existing Authorized Branch Locations:** \_\_\_\_\_

**i. Number and Types of New Emergency Medical Service Vehicles Being Requested.**

- |                          |                                   |               |
|--------------------------|-----------------------------------|---------------|
| <input type="checkbox"/> | Ambulance(s)                      | Number: _____ |
| <input type="checkbox"/> | EMS Vehicle(s) (non-transporting) | Number: _____ |
| <input type="checkbox"/> | Invalid Coach(es)                 | Number: _____ |
| <input type="checkbox"/> | Branch Location(s)                | Number: _____ |
| <input type="checkbox"/> | Air Ambulance(s) - Fixed Wing     | Number: _____ |
| <input type="checkbox"/> | Air Ambulance(s) – Helicopter     | Number: _____ |
| <input type="checkbox"/> | EMS Water Craft                   | Number: _____ |
| <input type="checkbox"/> | Charging for Service              |               |

**Projected Location of Headquarter’s Offices and Branch Locations:**

\_\_\_\_\_

**j. Geographic Area and Population to be Served in Implementing the Proposed Service.**

**Population Estimates:** \_\_\_\_\_

**List Boundaries of Proposed Service Area (To be outlined on map)**

**Total Number of Projected Calls the Applicant Service will Respond:** \_\_\_\_\_

**The Source and Volume of Projected Responses in Proposed Service Area:**

\_\_\_\_\_

**Identify EMS Regions Affected:** \_\_\_\_\_

k. **Source and Volume of calls 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 number:** \_\_\_\_\_

**Other Sources:** \_\_\_\_\_

l. **Total Number of Calls a Licensed Applicant Refused over the past 12 months and the circumstances for refusal:** \_\_\_\_\_

**Major Reason(s) for Refusal of Requests for Service:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**\*Attach additional sheets if necessary**

m. **Source and volume of calls expected over the next 12 months.**

\_\_\_\_\_  
\_\_\_\_\_

n. **Average Response Times over the past 12 months for a currently licensed applicant.**

**“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.**

**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 the plan for collecting fractile response time data. (Attach an additional sheet if necessary.)**

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**ATTACHMENTS**

- o. Provide evidence of paid-in working capital or binding credit agreement which equals a combined total of six months operating expenses. (Please provide on separate sheet)**

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- p. Provide an analysis of how the proposed service will integrate with the current Emergency Medical Service system.**

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- q. Provide an analysis of the improvement in cost effectiveness to the provider as a direct result of the proposed service.**

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- r. Proof of Insurance or letter of intent for new services.**

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- s. Any Other Information may be Included by the Applicant.**

