



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Primary Service Area Responder Application Process

1. 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.
2. 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 LETTERS OF ENDORSEMENT AND CERTIFICATE OF INSURANCE

3. A letter from the Chief Elected Official of the town or political jurisdiction in which the first responder service is to be provided supporting the application; and
4. A letter from the Chief Executive Officer of the EMS Organization that is designated Primary Service Area Responder (PSA holder) at the First Responder level service supporting the application; and
5. Certificate of Insurance forms:
 - a. Proof showing General or Public Liability Insurance
 - b. Malpractice Insurance (also known as Professional Liability)

Send this original application to the address listed below and send a copy to your Regional EMS

**Department of Public Health
Office of Emergency medical Services
410 Capitol Avenue, MS#12EMS
PO Box 340308
Hartford, CT 06134-0308
(860) 509-7975**

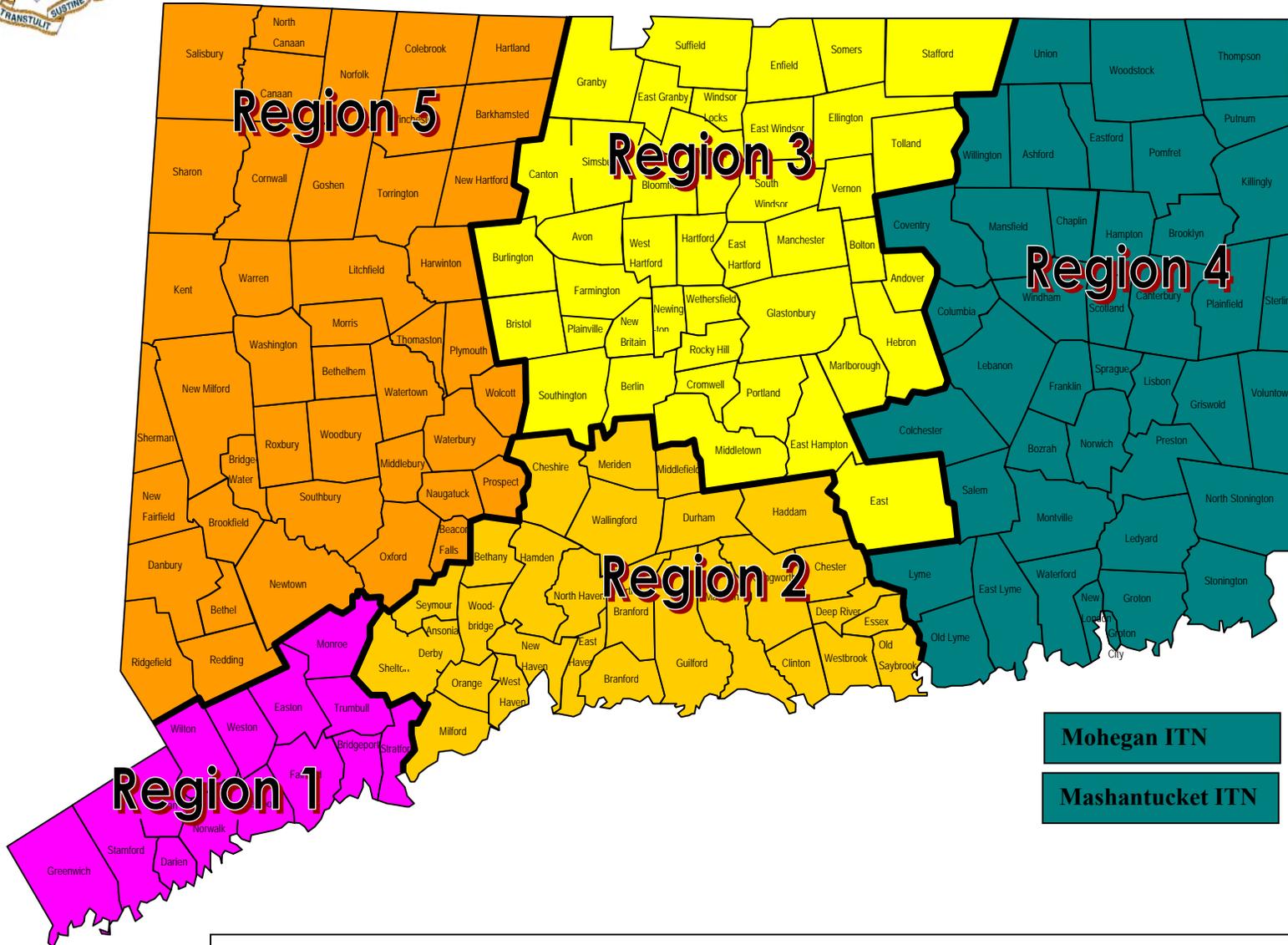
Rev: 4/9/2010



Phone: (860) 509-7975
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12EMS
P.O. Box 340308; Hartford, CT 06134
An Equal Opportunity Employer



STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH



CONNECTICUT EMERGENCY MEDICAL SERVICE REGIONS
Effective: January 1, 2008

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 ()

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: _____

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.

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: _____

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

NAME (please print): _____

TITLE: _____

MUNICIPALITY: _____

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

SIGNATURE: _____ DATE: _____

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.

Chief Executive Officer

Date