

## AMBULANCE LICENSURE APPLICATION FORMS

Enclosed are instructions and forms to apply for licensure to operate an ambulance service, to change or add a new base of operation, to offer a new type of service, or to expand a currently EMSRB-designated primary service area.

A Minnesota based and licensed ambulance service must apply for a new license to provide a new type of service, (e.g., to change type of service from basic to advanced ambulance.)

Submit **one printed (typed, word processed or similar), unbound copy** of the application and all documentation to the EMSRB at the above address. Retain a complete copy for your records.

For technical assistance to complete this application, please contact the appropriate EMS Specialist from the EMSRB staff personnel list. The designated EMS regional program may also be of assistance. EMSRB Minneapolis staff is available for questions of a general nature.

An application received by the EMSRB Minneapolis office is reviewed initially for completeness by staff. The application is considered complete when all information and documentation has been received as required by Minnesota Statute and Rules governing ambulance operations in Minnesota. Official notice will be published in the *Minnesota State Register* and appropriate newspapers as required by statute. The applicant will be billed for all notices published. The EMSRB will forward copies of the **Notice of Completed Application and, if applicable, Notice of and Order for Hearing** to appropriate agencies as required by statute.

Review carefully Minnesota Statutes, Section 144E.11, wherein the requirements and process for ambulance licensure application are described.

Enclosures:

Fee statement  
Instructions and Application: Part I  
Instructions and Application: Part II  
Primary Service Area Requirements  
EMSRB Staff Directory

Rev 6/2007

## **MINNESOTA AMBULANCE SERVICE LICENSE APPLICATION FEE STATEMENT**

The initial fee for application for a license to operate an ambulance service or to offer a new type of ambulance service is **\$150.00**.

The fee must accompany the enclosed application.

Attach a check or money order made payable to "Treasurer, State of Minnesota" to this application.

Upon approval of a new license, an additional fee for each vehicle will be assessed.

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# MINNESOTA AMBULANCE SERVICE LICENSURE APPLICATION

## INSTRUCTIONS: PART I

Provide all information requested by this application form. Be sure to sign on the last page. Incomplete applications will be returned. If exact financial data is not available, estimate as accurately as possible. Current license holders applying for a different level of service must provide financial projections for the new type of service, not the current level of service. The review and decision by the Emergency Medical Services Regulatory Board (EMSRB) will be made on the basis of information provided in this application.

If you have questions regarding this application form, please contact the appropriate EMS Specialist or the licensing staff for the EMSRB.

### 1. Service Name

- The service name must be the public business name. This will be the name visible to the public on the licensed ambulance vehicles.
- All correspondence from the EMSRB will be mailed to this address.

#### Manager

This is the person to contact at the business phone number. This person must be familiar with the general management and operation of the entire service.

### 2. Telephone

Provide the business phone number and fax number (if applicable) of management during normal business hours. Provide an alternate phone number if necessary, and (optional) pager number. Include area codes with all numbers.

### 3. Base of Operations

Provide the street address for the base of operation. This must not be a post office box number.

### 4. Type of Service

Check the type of service for the proposed license.

### 5. Type of Operation

Check the type of operation that best describes who is or will be responsible for operating this ambulance service. Check one box only.

### 6. Volunteer Status

Check the box that describes the volunteer status of the employees. (Volunteer ambulance attendant is defined as a person making less than \$6000 per year from their services on the ambulance and whose livelihood does not depend on the volunteer pay). Partially paid includes a service with at least one person paid along with volunteers.

**7. Ownership**

- a. Provide the name of the person, partnership, association, corporation or unit of government applying for this ambulance license. If this entity is incorporated within the State of Minnesota, give the official corporate name.
- b. Provide the address to direct correspondence specifically for the owner of the service. (e.g., city, government offices, corporation)
- c. Check the appropriate box that describes the legal status of the applicant identified as the owner. (e.g., a city fire department would check "city").

**8. Substations**

List locations (if applicable) that are distinct from the base of operation and from which additional vehicles, personnel and equipment will operate. These must also be a street address, not a box number.

**9. Medical Director(s)**

Provide the name, address and phone number of the physician medical director(s) with whom the service has a written agreement to provide medical direction. The agreement with the Medical Director must include statements that the physician will:

- Approve standards for training and orientation of personnel;
- Approve standards on upgrading and purchasing equipment;
- Establish all standing orders for the provision of patient care;
- Establish triage, treatment, and transportation protocols for adult and pediatric patients;
- Participate in the development of an internal quality assurance program;
- Establish written procedures for administration of medications;
- Assure annual skill verification of ambulance personnel.

An ambulance service is required to have a Minnesota licensed physician medical director.

If applying for licensure as an advanced or advanced-specialized ambulance service, submit with this application a copy of all appropriate documentation including standing orders, contract for services, and a statement from the physician medical director stating in detail precisely what equipment will be carried on licensed vehicles. Copies of these documents must be maintained in a licensure file with other required documentation. It is necessary to require copies of this documentation to assure adequate information for the EMSRB review of initial licensure of advanced service. All such statements must be maintained in the licensee's files for inspection by the EMSRB EMS Specialist after a license is issued.

State whether the physician(s) has been trained in Advanced Cardiac Life Support and/or Advanced Trauma Life Support.

State whether the medical director volunteers his/her services.

**10. Affiliated Medical Institution / Base Hospital**

If the ambulance service is affiliated with a medical institution/base hospital provide the name, address, phone number and administrator's name for the affiliated medical institution.

**11. Mutual Aid Agreements**

Ambulance services must provide documentation of one local mutual aid agreement (Minnesota Rule 4690.3700). It is suggested, but not required, that a mutual aid agreement be established with at least one "advanced" ambulance service, if possible, for possible intercept and for potential disaster situations.

Provide the name, EMS#, and location of the base of operation for at least one neighboring service (Minnesota-licensed), with a written agreement to provide back-up coverage. This back up coverage agreement is required. Copies of these agreements must be submitted with the application.

**12. Response Times**

Estimate the maximum response time at maximum allowable speeds to the most distant part of the proposed primary service area. The initial designation of a primary service area is based in part on the anticipated maximum response time to the most distant boundary. Provide as an estimate of the average response times for all runs.

If this application is for "specialized" licensure, specify travel times within the requested PSA. If travel times are not applicable (e.g., fixed wing aircraft or helicopters), enter not applicable.

**13. Population to be Served**

Provide up-to-date census information for persons residing within the boundaries of the requested primary service area and an estimate of the number of visitors to the area on an annual basis. The EMS regional project or community health service agency may be of assistance in providing this information.

**14. Utilization**

Estimate the number of each type of run anticipated by the proposed service in the next 12-month period.

If applying for an advanced license, estimate each type of run even if all calls will have advanced response.

Specialized advanced or specialized basic transports are made according to a pre-arranged schedule (patient transfers during which care was offered or provided).

**15. Revenue and Cash Contributions**

Estimate the total operating revenues from each of the following sources during the next twelve month period:

**Annual from operations:** include patient fees for services and third-party payments from all sources of insurance, including public, private and self-pay;

**Annual non-operating revenue:** include all revenues received which are not directly related to the provision of a specific service to a particular individual. Revenues include: grants, gifts, donations, subsidies, reimbursement for volunteer training, contracts, interest payments.

## 16. Revenue Sources

Estimate of the percentage of revenue from the various sources that will be used to operate the service. Use whole numbers.

## 17. Non-Cash Contributions

State, regional, and local planning efforts can be enhanced if officials are aware that the public is contributing to ambulance services. The estimated cash value of donated contributions to the proposed service are reported here. Do not include contributions or costs already included in item 16.

**Volunteer staffing:** If the service will be staffed by volunteers, use at least the minimum wage multiplied by the number of hours volunteer staff is on active call. By law, a licensee must have at least two persons available at all times. Also include donated time for training, medical direction, and administration.

**Equipment, vehicles, facilities, space:** If the service will pay no rent for its use of a base of operation or substation, include an estimate of the value of this space from the donating source (city, hospital, etc.). Provide estimates of other non-cash contributions to the service for major items of equipment (radios, pagers, defibrillator, etc.) and vehicles received during the first year of service.

**Other Contributions:** Provide the estimated value of donated supplies, publicity, insurance, and other contributions for which no cash is received.

## 18. Average Patient Charges

Provide average patient charges for each type of service listed. Standard charges are acceptable provided it is a meaningful estimate of the average charge made per patient. If charges vary dependent on type of service provided, estimate the average charge per patient for each type of service listed and explain fully on an attached sheet.

Use definitions for the three categories of service described in number 14 above.

If uniform charges are made regardless of the type of service provided, the average charge will be the same for each category of service provided. If more convenient, attach a standard charge sheet for the service.

## 19. Expenses

Provide total estimated annual operating expenses in each of the following categories:

**Personnel:** includes all employee salaries, fringe benefits and training costs.

**Capital related:** includes depreciation computed for the purchase of reusable equipment (ambulances, radios, pagers), the cost of purchasing, renting and improving buildings, interest expenses on capital-related items, etc.

**Estimated uncollectible accounts:** includes losses from service charges which were uncollectible, due to bad debts or lack of third-party reimbursement.

**Vehicle operations:** gasoline, repairs, tires, licenses, etc.

**All other expenses:** includes non-vehicle license fees, insurance, equipment maintenance and repairs, consumable supplies, rent payments, taxes, etc.

**20. Method of Accounting**

Indicate the method of accounting used by the service.

**21. Personnel**

Provide the name and phone numbers of individuals responsible for the following:

- a. **On-Site inspection:** a person available during the day that can be located for an on-site inspection of the service by an EMSRB representative.
- b. **Training:** a person responsible for maintaining current ambulance personnel training records.

**22. Radio Communications**

Information should be as accurate as possible. If not familiar with the frequency and tone capabilities of the system, contact the EMS Specialist in your area.

**23. Current Personnel Roster**

Provide the number of attendants and drivers on the service roster who possess current certification at one of the stated levels of training.

Provide a copy of a current roster including the name and certification level (Minnesota EMT, EMT-I or Paramedic) card # and the expiration date of the card. If qualified personnel have not yet been identified, provide a plan for hiring or training personnel. A roster form is provided for completion.

**24. Vehicles**

List each vehicle to be licensed as an ambulance. If vehicle(s) have not been acquired, list the specifications proposed for vehicles.

**25. Certification of Accuracy**

Sign the application or it will be considered incomplete and returned. EMSRB staff will determine whether an ambulance license application is complete. The decision may be to accept an application or to request additional information.

## **REQUIRED DOCUMENTATION**

Attachments listed must be submitted with any application for a new service. Attachments may vary depending upon the specific application and type of service. The application process will not begin until the application is complete. Allow an ample amount of time for the entire licensure process to be completed.

## **ATTACHMENTS**

Please list and number additional attachments submitted with the application. Please keep a file copy of the application for your reference as the review process progresses.

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## Application Requirements - Part II

A complete application must address each of the following four criteria found in Minnesota Statutes § 144E.11, subdivision 6. Address each statutory requirement separately and attach corresponding documentation.

### 1. Letters of Support

**Statute:** The recommendations or comments of the governing bodies of the counties, municipalities, community health boards as defined under section 145A.09, subdivision 2, and emergency medical services system designated under section 144E.50 in which this service would be provided.

**Explanation:** Submit written recommendations or comments in support of this application from the governing bodies of the counties, municipalities, community health boards and emergency medical services systems in which this service will be provided. Letters of support can be submitted as part of the application or directly to the EMSRB. Please note that for purposes of licensure application review by the EMSRB, only official letters from governing bodies of counties, municipalities, community health boards, and regional emergency medical services systems (144E.50) meet this statutory requirement.

### 2. Deleterious Effects on the Public Health Caused by Duplication of Service

**Statute:** The deleterious effects on the public health from duplication, if any, of ambulance service that would result from granting this license.

**Explanation:** List providers of ambulance service whose state-designated PSA overlaps with your proposed PSA. Document fully how duplication of service will be a positive benefit for providers and consumers in the PSA requested.

If other providers do not comment on/or object to the application, the applicant has the duty of demonstrating that the duplication in service will not create deleterious competition. Please refer to the last paragraph of the section of guidelines captioned Primary Service Area Description for a discussion of the type of evidence that should be offered if there are overlapping PSAs.

### 3. Effect on Public Health

**Statute:** The estimated effect of the proposed service, or expansion in PSA on the public health.

**Explanation:** Document fully how the proposed new service or proposed change in license:

- a. will benefit in a positive way the health status (mortality, morbidity) of the population to be served;
- b. will affect any specific health problems of the population to be served;
- c. will provide a more positive public health benefit in the proposed or current PSA than is now available.

### 4. Costs Association with Change in Service

**Statute:** Whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, or expansion in primary service area.

**Explanation:** Describe how the benefits of the proposed new service or change in license outweigh the cost of providing the service. Provide any documentation that clarifies costs associated with a proposed licensing upgrade.

## Requirements for Primary Service Area Description

The EMSRB has the duty to examine each application from an EMS system-wide perspective. The EMSRB must determine whether or not granting a new or upgraded license is in the best interest of the public health based upon the evidence contained in the record, and other applicable evidence including various court decisions that have been interpreted and applied to the ambulance licensing law.

Minnesota Rules, part 4690.3400 describes the requirements for initial designation of a PSA. Describe your **proposed** PSA using the township and range number (i.e. T110NR24W), or if not changing a current state designated PSA, submit a copy of your current PSA as part of the application. If providing a description, use **whole sections** within townships in your PSA. **Do not** use popular township names or describe partial sections within townships. Also, submission of a map showing PSA boundaries would be helpful. Mark on the map the base of operation location with a B and any substation locations with an S.

In the case of existing overlapping PSAs, or the creation of overlapping PSAs, the EMSRB strongly urges providers to voluntarily define their PSA boundaries through one of two options: withdrawal or summary approval.

**Withdrawal:** This process requires a letter addressed to the EMSRB from a license holder indicating the desire to remove a specified area or areas from the state-approved PSA. The letter must be signed by the chief administrative officer and must identify the specific geographic area requested to be removed from the designated PSA. The area must be identified by township and whole township sections. Documentation must include what ambulance service will be providing service within the proposed area of withdrawal.

**Summary Approval:** Assuming you currently have a Minnesota license and there is agreement with the other Minnesota licensed ambulance company(ies), the application may submit documentation required by Minnesota Statutes § 144E.07 for summary approval of an expanded PSA.

The applicant requesting to provide service in a geographic area that is within the primary service area of another licensed ambulance service or services must submit documentation from the service or services whose primary service areas overlap the proposed expansion area, approving the expansion and agreeing to withdraw any service coverage from the proposed expanded area. The application may include documentation from the public safety answering point (PSAP) coordinator or coordinators endorsing the proposed change. If objections to the application are made by ambulance licensees whose PSAs are directly affected by the application, the EMSRB will request that the application revert to the statutory process which may require a public hearing.

**Non-Resolved Overlaps:** For PSA overlaps that cannot be resolved through either the withdrawal process or the summary approval process, the alternative for the applicant is to compile and submit evidence that will explain the impact of the application on the other providers whose PSAs overlap within the PSA of the applicant. Evidence should include, but not be limited to, the degree to which each ambulance company provides service in those areas, how that is impacted by 911 boundaries, and current transport practices with statistical data providing the actual number of runs by the specific ambulance service in an overlapping area. If only one provider is serving an overlap area, explain why and what circumstances might cause that situation to change. If more than one ambulance license services an overlap area, provide evidence to show the impact on other licensed service(s) if the license is granted. The information must be specific, and must include current and historical run data. Within a PSA with more than one licensee, will there be an attempt by the applicant, if granted a license, to compete for all calls? Describe the current 911 PSAP policy and if there will be any change if the license is granted.

Identify what policies will be established, if any, for intercept agreements or interfacility transfers in an overlapping area, including scheduled, 911 emergency calls or non-emergency 911 calls.

Where there are PSA overlaps, the EMSRB may grant a new or upgraded license within those areas when the evidence taken as a whole established that there is a need for the applicant's proposed license when considered in light of the statutory criteria outlined in Minnesota Statutes § 144E.11 (see part II of the license application.) One of the significant factors to be considered as shown in previous decisions is whether the applicant is or will become the primary provider in the overlapping areas. When need is established, the EMSRB may grant a license that results in duplication of service. When the EMSRB does not grant a licensure upgrade in overlapping areas, the applicant will remain licensed at its current level.

Required Criteria for Ambulance Upgrade  
From Basic to Advanced Ambulance Service

1. All Minnesota licensed ambulance services must obtain a new license to provide a new type or types of service. (Minnesota Statutes § 144E). An application must be completed in duplicate on a form provided by the EMSRB. This application form is available from the EMSRB.
2. EMSRB Application Form - Part I  
Application form Part I is self explanatory, but special attention must be given to the following required documentation:

**Agreement with Medical Director:** This agreement must include statements that the physician will:

- Approve standards for training and orientation of personnel;
- Approve standards for purchasing equipment and supplies that impact patient care;
- Establish all standing orders for the provision of patient care;
- Approving written triage, treatment and transportation guidelines for adult and pediatric patients;
- Participate in the development of continuing quality improvement program;
- Establish procedures for the administration of medications;
- Assure an annual skills verification of each person on the roster. (Minnesota Statutes § 144E.265)

**Protocols:** Protocols (adult & pediatric) must be submitted as part of the application. Protocols must include a list of narcotics that have been approved by the medical director for use in the ambulance, and the policy for disposal and storage.

**Mutual Aid Agreements:** Ambulance services must provide documentation of one local mutual aid agreement (Minnesota Statutes § 144E.101, subdivision 12). Note: It is suggested, but not required, that a mutual aid agreement be established with at least one advanced ambulance service.

**Personnel Roster:** If available a roster must be submitted. If qualified personnel have not yet been identified, provide a plan for hiring or training personnel. Personnel identified on the roster must meet requirements of Minnesota Statutes § 144E.101 subdivision 11.

3. EMSRB Application Form – Part II. Part II of the license application requires that four specific criteria in Minnesota Statutes §144E be addressed. These criteria are a very important part of the application process and are used by the EMSRB to make a final decision.
4. Complete Application/Decision from the EMSRB. The EMSRB will make a decision on whether the ambulance license application is complete and begin the public review process. After it is determined that an application is complete the public review process usually takes from two to four months, including the EMSRB final decision. This assumes a “non-controversial” public process. If the license is granted, the ambulance service must pass the inspection conducted by EMSRB staff prior to beginning the operation of the service.

## **Required Criteria for a Specialized Ambulance Service License Application**

1. A prospective licensee must obtain a license to provide a new type or types of service (Minnesota Statutes 144E). An application must be completed in duplicate on a form provided by the EMSRB. This application form is available from the EMSRB.
2. EMSRB Application Form - Part I. Application form Part I is self explanatory, but special attention must be made to the following required documentation:

**Agreement with Medical Director.** This agreement must include statements that the physician will:

- Approve standards for training and orientation of personnel;
- Approve standards for purchasing equipment and supplies that impact patient care;
- Establish all standing orders for the provision of patient care;
- Approving written triage, treatment and transportation guidelines for adult and pediatric patients;
- Participate in the development of an internal quality improvement program;
- Provide written procedures for the administration of medications;
- Assure an annual skills verification of each person on the roster. (Minnesota Statutes § 144E.265)

A medical director's agreement is required even if an arrangement has been made to have nurses or physicians assistants from the hospital provide staffing for interfacility transports.

**Protocols:** Protocols (adult and pediatric) must be submitted as part of the application. For advanced services these protocols must include a list of narcotics that have been approved for use in the ambulance, and the policy for disposal and storage.

**Mutual Aid Agreements:** Mutual Aid Agreements are typically not required of specialized services, but it is recommended that an agreement with another licensed service be available for back-up in case of service unavailability or a disaster situation.

**Personnel Roster:** If available a roster must be submitted. If qualified personnel have not yet been identified, provide a plan for hiring or training personnel. Personnel identified on the roster must meet requirements of Minnesota Statutes § 144E.101 subdivision 11. If personnel are not EMTs and/or Paramedics, documentation must be submitted that indicates that all attendants are trained to use all of the equipment in the ambulance.

**Schedule of Services.** A specialized license is one that provides basic or advanced ambulance services and is different from an "emergency" basic or advanced ambulance service in that it restricts its operation to specific hours of the day (it may identify daytime operations only), specific segments of the population (such as transfers from one health care facility to another or services by air), or certain types of medical conditions (cardiac care services, neo-natal services). The most common type of specialized service is for advanced specialized ambulance service that provides inter-facility transfers beginning from a designated health care facility. A schedule of operations must be submitted with the application that details any provision of care that does not fall under the normal standard of care provided by an emergency ambulance provider. A schedule may include, for example:

- the use of registered nurses rather than EMTs or paramedics as attendants. (If using nurses from the hospital, a copy of the agreement between the ambulance service and hospital should be submitted);
- use of prepackaged equipment;
- neo-natal services only.

Any provision of the rules may be waived or changed as part of a schedule. To request a waiver or variance to any part of the MN Rules Chapter 4690, the applicant must explain how the proposed change will benefit the public health.

- 3. EMSRB Application Form - Part II.** Part II of the license application requires that four specific criteria in Minnesota Statutes § 144E be addressed. These criteria are a very important part of the application process and are used by the EMSRB to make a final decision.
- 4. Complete Application/Decision from the EMSRB.** The EMSRB will make a decision on whether the ambulance license application is complete and begin the public review process. After it is determined that an application is complete, the public review process usually takes from two to four months, including the EMSRB final decision. This assumes a “non-controversial” public process. If a decision to approve the license is made, a successful inspection must occur prior to beginning the operation of the service.

**Change of ownership  
must be approved by EMSRB**

Minnesota Statutes § 144E.14 states: "A license, or the ownership of a licensed ambulance service, may be transferred only after approval of the Board, based upon a finding that the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of section 144E.16. If the proposed transfer would result in a change in or addition of a new base of operations, expansion of the services primary service area, or provision of a new type or types of ambulance service, the Board shall require the prospective licensee or owner to comply with 144E.14. The Board may approve the license or ownership transfer prior to completion of the application process described in 144E.14 upon obtaining written assurances from the proposed licensee or proposed new owner that no expansion of the service's primary service area, or provision of a new type or types of ambulance service will occur during the processing of the application. If requesting a transfer of its base of operation, an applicant must comply with the requirements of section 144E.15."

A change of ownership application must include the following information:

1. A letter from the current owner indicating their intent to transfer the ownership of the license.
2. A letter from the proposed new owner indicating the intent to obtain ownership of the license. This letter must specify that all requirements of Minnesota Statutes and Minnesota Rules applying to ambulance services will be met (Minnesota Statutes Chapter 144E and Minnesota Rules, Chapter 4690). It must also state that no addition of a new base of operations, expansion of the services primary service area, or provision of a new type or types of ambulance service will occur during the processing of the application for change of ownership. If any of these criteria are not met, the EMSRB may require the new owner to comply with 144E.11 (ambulance service application procedure).
3. An application that furnishes information about the owner will be provided by the EMSRB.

When all information as required by the statute is received, a board order to transfer ownership will be generated. The current owner and the new owner will be informed when the EMSRB order has been signed. Ownership of an ambulance license is not legally transferred until the date of the EMSRB approval.

The issue date of the license will not take place prior to the date which the EMSRB has signed the order.

**Part I**  
**Application for License**  
**To Operate an Ambulance Service in Minnesota**

- |   |  |
|---|--|
| <input type="checkbox"/> NEW LICENSE                          | <input type="checkbox"/> CHANGE IN TYPE OF SERVICE   |
| <input type="checkbox"/> CHANGE IN PSA (non-summary approval) | <input type="checkbox"/> CHANGE IN BASE OF OPERATION |

**1. Service Name**

Service Name		
Business Address		
City	State	Zip
Manager		

**2. Phone Numbers**

Daytime	
Alternate	
Fax	
Email	
Pager	

**3. Base of Operation**

Address or location		
City	State	Zip
County		

**4. Type of Service**

- |  |   |
|--|---|
| <input type="checkbox"/> Basic Ambulance                   | <input type="checkbox"/> Advanced Ambulance                   |
| <input type="checkbox"/> Basic Ambulance Specialized       | <input type="checkbox"/> Advanced Ambulance Specialized       |
| <input type="checkbox"/> Basic Ambulance Specialized (Air) | <input type="checkbox"/> Advanced Ambulance Specialized (Air) |
|  | <input type="checkbox"/> Part-Time Advanced Ambulance         |

**5. Type of Operation**

- |                                   |                                  |   |
|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> Fire     | <input type="checkbox"/> Police  | <input type="checkbox"/> Other Public Service |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Private | <input type="checkbox"/> Other                |

**6. Volunteer Status**

All Volunteer<sup>1</sup>

Partially Paid

All Paid

## 7. Ownership

Owner Name		
Business Address		
City	State	Zip

### Ownership Type

County

Hospital

Nonprofit Corporation

Partnership

City

U.S. PHS

Individual

For Profit Corporation

City/County

Federal

Other Nonprofit

Tribe

License Owned by a Licensed Health Care Facility

Yes

No

## 8. Substations

List substation location(s) where vehicles, personnel or equipment will be located (substations must be within the primary service area.)

Address or location		
City	State	Zip
County		

Address or location		
City	State	Zip
County		

## 9. Medical Director(s)

Physician's Name		
Address		
City	State	Zip
Phone Number		

Has the physician been trained in Advanced Cardiac Life Support?

Yes

No

Has the physician been trained in Advanced Trauma Life Support?

Yes

No

<sup>1</sup> Volunteer ambulance attendant is defined as a person making less than \$6,000 per year from their services to the ambulance and whose livelihood does not depend on the volunteer pay.

Does the physician volunteer services as medical director?

Yes

No

Physician's Name		
Address		
City	State	Zip
Phone Number		

Has the physician been trained in Advanced Cardiac Life Support?

Yes

No

Has the physician been trained in Advanced Trauma Life Support?

Yes

No

Does the physician volunteer services as medical director?

Yes

No

**10. Affiliated Medical Institution/Base Hospital, if any**

Institution		
Address		
City	State	Zip
Hospital Administrator		
Phone		

**11. Mutual Aid**

List current written agreements with Minnesota licensed service(s) to provide back-up coverage for ambulance service. Submit a copy of each agreement submitted with this application.<sup>2</sup>

Mutual Aid Service		EMS Number
City	State	Zip

Mutual Aid Service		EMS Number
City	State	Zip

Mutual Aid Service		EMS Number
City	State	Zip

Mutual Aid Service		EMS Number
City	State	Zip

<sup>2</sup> Agreements must be current, signed, and reviewed at least every 24 months. Attach additional sheets if necessary.

**12. Response Times**

Estimate the maximum and average response times from the base of operation or substation(s) to the most distant point within your primary service area.

Maximum Response Time  Minutes (most distant point)  
Average Response Time  Minutes

List the maximum distance from your base of operation or substation to the most distant point in your primary service area:

Miles

**13. Population To Be Served**

Provide the estimated population of residents and visitors in your primary service area (scheduled services need not answer).

Residents  Visitors

**14. Utilization**

Provide estimates for each type of ambulance run anticipated in the next twelve months. Ambulance Runs

Basic Runs   
Basic Specialized Runs   
Advanced Runs   
Advanced Specialized Runs   
  
Total Runs (All Types)

**15. Revenue And Cash Contributions**

Estimate the total operating revenue from all sources for the 12 months:

Annual from operations (fees for services, third party payment, etc.)  .00  
Annual non-operating revenues (subsidies, gifts, grants, contracts, interest, etc.)  .00  
  
Total Revenue and Cash Contributions  .00

**16. Revenue Sources**

Estimate the approximate percentage of revenue and cash contributions received from each of the following sources (these should total 100%). Round to the nearest **whole** percentage.

<b>Third party payment (Medicare, Medicaid, Private Insurance)</b>	%
<b>Patient charges (direct payment method)</b>	%
<b>Community Health Service subsidy</b>	%
<b>Other public subsidy or grant</b>	%
<b>Private grants, personal gifts</b>	%
<b>Training reimbursement</b>	%
<b>Other – specify</b>	%
<b>Total</b>	%

**17. Non-Cash Contributions**

Estimate the financial value of in-kind contributions projected for the next 12 months:

<b>Volunteer staffing (including medical director)</b>	.00
<b>Equipment, vehicles, facilities, space</b>	.00
<b>Other contributions (supplies, publicity, insurance, etc.)</b>	.00
<b>Total Annual Contributions</b>	.00

**18. Average Patient Charges**

Provide the expected patient charge for the first 12 months in service:

<b>ALS average patient charge (including scheduled)</b>	.00
<b>BLS average patient charge (including scheduled)</b>	.00
<b>Special transportation average patient charge (non-medical)</b>	.00

**19. Expenses**

Provide estimated annual operating expenses for the next 12 months at the level of service specified by this application:

<b>Personnel (salary and fringe)</b>	.00
<b>Capital-related (depreciation, interest on loans, etc.)</b>	.00
<b>Estimated uncollectible accounts</b>	.00
<b>Vehicle operations</b>	.00
<b>All other expenses</b>	.00
<b>Total Annual Expenses</b>	.00

**20. Method Of Accounting**

Accrual                       Cash                       Other, specify \_\_\_\_\_

**21. Personnel**

Provide the names and telephone number for individuals responsible for the following:

On-site inspection by the EMSRB

Name	Phone
Fax	Pager/cell

Training and continuing education for personnel:

Name	Phone
Fax	Pager/cell

**22. Radio Communication**

Local District VHF Frequency

Other VHF Frequency

800 MHz

Call Sign

Do you have a MINSEF (MN State Emergency Frequency) Channel  Yes  No

Do you have National 155.340 capability?  Yes  No

Is your service dispatched through a "911" public service answering point?  Yes  No

Are all your ambulances able to communicate by two-way radio with:

All hospitals in your primary service area (PSA)?  Yes  No  
 The ambulance services in neighboring PSAs?  Yes  No  
 Hospitals in neighboring PSAs?  Yes  No

**23. Personnel Roster**

List the number of personnel on the service roster with current EMT cards at the following training levels.  
 List the highest training level for each employee.

	Volunteer <sup>3</sup>	Paid
Emergency Medical Technician		
Emergency Medical Technician-Intermediate		
Emergency Medical Technician-Paramedic		
First Responder		
Other: (R.N., M.D., P.A.)		
<b>Total number on active roster</b>		

<sup>3</sup> Volunteer ambulance attendant is defined as a person making less than \$6,000 per year from their services to the ambulance and whose livelihood does not depend on the volunteer pay.





**Required Documentation to be Attached**

- Medical Direction Agreements**
- Guidelines or protocols for adult and pediatric patients**
- Mutual Aid Agreements**
- Personnel Roster (if available)**

**Other Attachments**

Please list and identify by attachment number)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_