The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
Office of Emergency Medical Services
Mobile Integrated Health Care Program
99 Chauncy Street, 11th Floor, Boston, MA 02111

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

Draft

Application for Approval
Community EMS Program

INSTRUCTIONS

This application form is to be completed by a local public health authority in partnership with the primary ambulance service in the relevant local jurisdiction, that wishes to apply for a Certificate of Approval to operate a Community EMS Program. The application is intended for proposed service(s) of the applicant, in the jurisdiction over which the local public health authority has authority and in which the partnered ambulance service is the primary. The application must be received by the Department of Public Health (Department) at least 30 days prior to anticipated commencement of Community EMS Program operations.

Unless indicated otherwise, all responses must be typed into the application forms. Handwritten responses will not be accepted. Please note that character limits include spaces.

Attachments should be labelled or marked so as to identify the question to which it relates.

Each submitted application must be a complete, collated response, printed single-sided, and secured with a binder clip (no ring binders, spiral binding, staples, or folders). Please submit one copy of the application.

Mail or hand-deliver the Application for Approval, with all required attachments, and the application fee payable to:

Department of Public Health
Mobile Integrated Health Care
Application for Approval
99 Chauncy Street, 11th Floor
Boston, MA 02111

Application fees are non-refundable and non-transferable.

REVIEW

Applications are reviewed in the order they are received.

After a completed application packet is received by the Department, the Department will review the information and will contact the applicant if clarifications/updates to the submitted application materials are needed.

If the applicant does not hear back from the Department after 30 days from its receipt of the application, the applicant may commence operation.

PUBLIC RECORDS

Please note that all application responses, including all attachments, will be subject to release pursuant to a public records request.

REGULATIONS

For complete information regarding approval of a Community EMS Program, please refer to 105 CMR 173.000. It is the applicant's responsibility to ensure that all responses are consistent with the requirements of 105 CMR 173.000, and any requirements specified by the Department, as applicable.

QUESTIONS

If additional information is needed regarding the MIH application process, please contact the MIH Program at (617) 753-8000 or MIH@state.ma.us.

APPLICATION ATTACHMENT CHECKLIST

- [x] This Application
- [x] Description and evidence supporting any proposed non-pre-approved service(s)
- [ ] Application Resubmission. If this is a Re-submission, please include your previous application number in the box on the below. Your application number or ID is provided on the email/last page of the previous application if it was saved

  Previous Application Number : 12121457897978

1. APPLICANT INFORMATION

Name of Local Health Board / Public Health Authority: Department Of public health

Date: 06/08/2017

Address of Local Health Board / Public Health Authority: 99 chauncy street

Street

boston | ma | 20108

City | State | Zip Code

Name of Contact Person: veera subrama

Title: doctor

Telephone Number: (999) 999-9999

E-Mail Address: veera@states.ma.us

Name of Authorized Signatory: rajehsg kumar

Signature of Authorized Signatory: Digitally signed by veera DN: cn=veera, o=eohss, ou, email=veerappanvs@gmail.com, c=US Date: 2017.06.02 14:20:45 -04'00'

Name of Clinically Affiliated Hospital Medical Director: chakra bat

Title: directior

Telephone Number: (888) 888-8888

E-Mail Address: cha@gma.com

Proposed Program Start Date: 07/01/2017

Number of EMS-Personnel in Proposed Program: 2

Number of EMT-Paramedics: 1

Operationally Affiliated Health Care Organizations: kjnsdcnaklncklacdlkmlasdmlcdcfasdcasdcasdcasdc

Program Funding: ☑ Agency funds/tax revenue ☑ Grant support ☑ 3rd party payers ☑ Other (describe): Testretse

For each jurisdiction covered by the proposed program, the primary ambulance service must be included. Please list each primary ambulance service and the applicable local jurisdiction(s) for each ambulance service included in the proposed program. Please also list the ambulance license number, contact name and title, telephone number, and e-mail address. *Please only list if the primary ambulance service(s) is separate from the applicant organization.*

Primary Ambulance Service	Applicable Local Jurisdiction(s)	Ambulance License Number	Ambulance Contact Name	Ambulance Contact Name Title	Ambulance Telephone Number	Ambulance E-Mail Address
1. ambul	boston	123456	kapoor & sons	flyer	(777) 777-7777	veeraa@gmail.com
2.						
3.						
4.						

Attestation:
In accordance with 105 CMR 173.000, the undersigned hereby applies for designation to establish a Community EMS Program as set forth under provisions of 105 CMR 173.000.

The undersigned representative(s) of the provider hereby attest that, (1) the information provided in and submitted with this document is accurate and correct to the best of my knowledge; (2) the failure to file a complete and accurate application for approval or renewal may constitute grounds for denial or revocation of approval; and, (3) pursuant to the applicant's responsibility as an approved Community EMS Program to comply with 105 CMR 173.000, the applicant understands and acknowledges the regulatory requirements of 105 CMR 173.000 and associated guidance documents, and is in compliance with the regulatory requirements of 105 CMR 173.000, and can provide verification of compliance upon request.


Digitally signed by veera
DN: cn=veera, o=eohss, ou, email=veerappanvs@gmail.com, c=US
Date: 2017.06.02 14:24:29 -04'00'

06/01/2017

Signature of Local Public Health Authority Authorized Signatory — Date Signed

officde 1

Print Name Local Public Health Authority Authorized Signatory

Senior director

Title of Local Public Health Authority Authorized Signatory


Digitally signed by veera
DN: cn=veera, o=eohss, ou, email=veerappanvs@gmail.com, c=US
Date: 2017.06.02 14:25:37 -04'00'

06/01/2017

Signature of Clinically Affiliated Hospital Medical Director — Date Signed

officer 2

Print Name of Clinically Affiliated Hospital Medical Director

director

Title of Clinically Affiliated Hospital Medical Director


Digitally signed by veera
DN: cn=veera, o=eohss, ou, email=veerappanvs@gmail.com, c=US
Date: 2017.06.02 14:25:58 -04'00'

06/01/2017

Signature of Primary Ambulance Service Authorized Signatory 1 — Date Signed

officer 3

Print Name of Primary Ambulance Service Authorized Signatory 1

executive director

Title of Primary Ambulance Service Authorized Signatory 1

Signature of Primary Ambulance Service Authorized Signatory 2 — Date Signed

Print Name of Primary Ambulance Service Authorized Signatory 2

Title of Primary Ambulance Service Authorized Signatory 2

Signature of Primary Ambulance Service Authorized Signatory 3 — Date Signed

Print Name of Primary Ambulance Service Authorized Signatory 3

Title of Primary Ambulance Service Authorized Signatory 3

Signature of Primary Ambulance Service Authorized Signatory 4 — Date Signed

Print Name of Primary Ambulance Service Authorized Signatory 4

Title of Primary Ambulance Service Authorized Signatory 4

2. PROGRAM OVERVIEW

a. **In 2,000 words or less, please describe** the program and proposed services, including addressing:
   i. The target population
   ii. The location of services,
   iii. The timing (beginning and end dates, and any seasonality) proposed for the program
   iv. All involved operational partnerships

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3. SERVICES PROVIDED

a. **Please indicate** which of the evidence-based illness and injury prevention services deemed high-value public health services with low risk potential to patients your program will provide, after referring to the list of allowable services online.

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b. For any service not listed online as a pre-approved allowable service, **please attach** a written request including a description of the service with appropriate supplemental evidence supporting the future inclusion in, or exclusion from, said guidelines of certain low-risk high-value evidence-based illness and injury prevention service(s).

4. ATTESTATIONS

a. I attest that the Community EMS Program will only operate and provide services and community outreach and assistance to residents of the local jurisdiction(s) in which the ambulance service is the primary service.

b. I attest that all EMS provider training and activities related to the Community EMS Program will be approved by the local public health agency and the primary ambulance service's affiliate hospital medical director.

c. I attest that the designated primary ambulance service's affiliate hospital medical director will:
   i. Ensure all EMS personnel providing services in the Community EMS Program successfully complete additional training tailored to meet the specific needs of the particular Community EMS Program
   ii. Review the quality of the EMS personnel's delivery of services
   iii. Ensure EMS personnel provide services only within their scope of practice

d. I attest that the program will ensure that the 9-1-1 EMS system will be activated and that the provider will continue to assess and treat a patient in accordance with clinical protocols until transfer of care to the responding ambulance service, if an assessment and medical direction indicates to an on-scene health care provider that the patient is experiencing a medical emergency.

e. I attest that the program will deploy a vehicle that, at a minimum, is a non-transporting vehicle appropriate for the clinical encounter, when responding to a Community EMS call or a scheduled home visit.

6/1/17

Signature of Local Public Health Authority Authorized Signatory | Date Signed

Officer 5

Print Name of Local Public Health Authority Authorized Signatory

staff

Title of Local Public Health Authority Authorized Signatory

Digitally signed by veera
DN: cn=veera, o=eohss, ou, email=veerappanvs@gmail.com, c=US
Date: 2017.06.02 14:30:47 -04'00'

6/1/17

Signature of Affiliate Hospital Medical Director | Date Signed

officer 3

Print Name of Affiliate Hospital Medical Director

senior staff

Title of Affiliate Hospital Medical Director

5. ADDITIONAL ATTACHMENTS

a. For any proposed service that is not listed online as a pre-approved service, **please attach** a written request including a description of the service with appropriate supplemental evidence supporting the future inclusion in, or exclusion from, said guidelines of certain low-risk high-value evidence-based illness and injury prevention service(s).

Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit Keep a copy for your records. Click on the "Save" button at the bottom of the page.
To submit the application electronically, click on the"E-mail submission" button.

This document is ready to file: ☑ **Date:** 06/02/2017 02:31 pm

Your Application Number: 10170602023145
Use this number on all communications regarding this application.

Save | Print | Reset

Add Attachment | Email Submission