Stanislaus County Sheriff's Office
Emergency Services Division

Jeff Dirkse
Sheriff/
Director of OES

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Chad Braner
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3705 Oakdale Rd, Modesto, CA 95357
Phone: 209.552.3600 Fax 209.552.2512

Stanislaus County
Emergency Medical Services Agency

General Application for the Provision of Non-Emergency Interfacility Ambulance Service in Stanislaus County

Applicants who wish to provide Non-Emergency ambulance services within Stanislaus County as administered by the Stanislaus County EMS Agency (hereafter referred to as the "EMS Agency") shall provide documentation in answer to the questions listed in this package. When answering the questions, please be as specific and complete as possible. An incomplete application may cause a delay in processing and may result in the denial of the application. An applicant who knowingly makes a false statement of fact in this application may be subject to denial of his/her application.

Once the application is completed, submit it to:

Stanislaus County EMS Agency
EMS Director
3705 Oakdale Rd.
Modesto, CA 95357

Upon receipt of the completed application, the EMS Agency, shall make, or cause to be made, an investigation to determine if the applicant meets all requirements as outlined in applicable laws, ordinances and regulations. Within ninety (90) days of receipt of the application the EMS Agency shall decide to issue, or decline to issue, an Ambulance Provider Agreement.

Stanislaus County
Emergency Medical Services Agency

Application for Non-Emergency
Interfacility Ambulance Services Certificate of Operation

☐ Initial Application ☐ Renewal Application ☐ Information Update

Applicant Name: _____

Company Name: _____

Company Address: _____
Street City State Zip Code

Phone: _____ **Fax:** _____ **Email:** _____

Service Level Requested: ☐ BLS ☐ ALS ☐ CCT

Have you ever provided ambulance service *within* Stanislaus County EMS Agency *and/or within* Stanislaus County? ☐ Yes ☐ No

If yes, what type of service: ☐ BLS ☐ ALS ☐ CCT

Company Name: _____

Length of Time: _____

Do you provide ambulance service *out* of Stanislaus County EMS Agency? ☐ Yes ☐ No

List counties: _____

If yes, what type of service: ☐ BLS ☐ ALS ☐ CCT

Company Name: _____

Length of Time: _____

Provide a 24-hour availability phone number for supervisory or management contact

Phone Number: _____

Stanislaus County
Emergency Medical Services Agency

General
Application for the Provision of Non-Emergency Interfacility Ambulance Service Components

- ✓ Please assemble the application components listed below into a binder and/ or PDF
- ✓ Each section or attachment must be identified by a divider marked with the lettering outlined below

☐ **Initial Application** ☐ **Renewal Application**

Attachments	Completed	Notes
A. Name, Title, and Contact Information of Person(s) completing this application	☐ Y ☐ N	
B. Provide Name(s) under which the applicant has engaged, does, or proposes to engage in ambulance service	☐ Y ☐ N	
C. List the Names, Addresses, and Contact Information of the Applicant(s), Registered Owner(s), Partner(s), Officer(s), Director(s), and Controlling Shareholder(s)	☐ Y ☐ N	
D. Submit a statement that verifies that the applicant owns or has under their control, in good mechanical condition, required equipment (please see EMS Agency Policy 407.00 – Transporting Ambulance Equipment and Supply Inventory) to consistently provide quality ambulance service in the area for which the applicant is applying, and that the applicant owns or has the access to suitable facilities for maintaining equipment in a clean and sanitary condition	☐ Y ☐ N	
E. Certificate of Operation Application	☐ Y ☐ N	
F. Describe the ambulance response area and type of ambulance service(s) proposed by applicant	☐ Y ☐ N	
G. Submit a description of the applicant's training and experience in the transportation and care of patients for applicable level of service(s) contracted to provide	☐ Y ☐ N	
H. A copy of the business license for the city(ies) in which the applicant will be doing business	☐ Y ☐ N	
I. A statement of the legal history of all applicants, including criminal, civil convictions, judgments, or liens	☐ Y ☐ N	
J. Submit a statement identifying any previous denial of authorization to provide ambulance service by an EMS Agency within the State of California, identifying the EMS Agency and reasons for denial of said authorization	☐ Y ☐ N	

Stanislaus County
Emergency Medical Services Agency

General
Application for the Provision of Non-Emergency Interfacility Ambulance Service Components
(Continued)

Attachments	Completed	Notes
K. A description of the company's training and orientation programs for EMTs, Paramedics, CCT-RNs and Dispatchers for applicable level of service(s) applying to provide	☐ Y ☐ N	
L. The company location(s) from which ambulances will be deployed, noting the hours of operation, phone numbers, and the total number and level (BLS, ALS, or CCT) of ambulances deployed on each shift for applicable level of services(s) contracted to provide	☐ Y ☐ N	
M. Evidence of insurance coverage compliance which meets or exceeds the requirement in California Vehicle Code Section 16500	☐ Y ☐ N	
N. A certificate of consent to self-insure issued by the California State Director of Industrial Relations or a Certificate of Workman's Compensation Insurance	☐ Y ☐ N	
O. Quality Management program and description of quality assurance activities	☐ Y ☐ N	
P. A Disaster Response Plan that includes a personnel call-back plan for disasters and mass casualty incidents	☐ Y ☐ N	
Q. The following financial information: • An assets and liabilities statement or a letter prepared by a certified public accountant showing proof of financial solvency • Pay scales, benefit packages and work schedules for line personnel for the first twelve (12) months of operation • Standard financial review for the applicant's previous fiscal year, prepared by a certified public accountant, which includes: general testing of revenue and expenditure figures, some analytical review of the data, and limited assurance as to the accuracy of the data supplied by the company's management	☐ Y ☐ N	

Stanislaus County
Emergency Medical Services Agency

General
Application for the Provision of Non-Emergency Interfacility Ambulance Service Components
(Continued)

Attachments	Completed	Notes
R. Statement validating the following technology will be in place by the start of service with Stanislaus County EMS Agency: • NEMSIS Compliant Electronic Patient Care Report Program with revision V3.4 or higher Data Dictionary reporting standards	☐ Y ☐ N	
S. Statement agreeing to participate in the Stanislaus County EMS Agency monitoring of Non-Emergency BLS, ALS or CCT transports/IFTs through FirstWatch for applicable level of service(s) contracted to provide. Statement must include the following: • "(Contractor's Name) will be responsible for all costs involved with the transmission of data or reporting or monitoring as required or stipulated by Stanislaus County EMS Agency or California Emergency Medical Services Authority (EMSA)."	☐ Y ☐ N	
T. Completion of the following attachments: • Attachment A – Additional Applicant Information	☐ Y ☐ N	
U. Submit a description of how the company will adhere to the following Stanislaus County EMS Agency Policies: • Non-Emergency EMS Dispatch Center Standards (Policy 314.00) • Ground Ambulance Equipment and Medical Supply Inventory (Policy 407.00) • Integration into Stanislaus County EMS Agency Quality Improvement Program (Policy 620.10) • EMD Provider Agency/Ambulance Provider Data Requirements (Policy 620.30) • All policies applicable to non-emergency ambulance ALS, BLS, or CCT inter-facility transport for applicable level of service(s) contracted to provide	☐ Y ☐ N	
V. Completion of the following attachments: • Attachment C – Signed Declaration Statement	☐ Y ☐ N	

Stanislaus County
Emergency Medical Services Agency

Attachment A
Additional Applicant Information

- ✓ Please list all other owner(s), partner(s), officer(s), director(s) and controlling shareholder(s)
- ✓ Please attach additional pages if necessary

☐ **No additional applicants**

Applicant Name: ______________________________

Business Address: ______________________________
Street City State Zip

Phone: __________ **Fax:** __________ **Email:** __________

☐**Registered Owner** ☐**Partner** ☐**Officer** ☐**Director** ☐**Controlling Shareholder**

Applicant Name: ______________________________

Business Address: ______________________________
Street City State Zip

Phone: __________ **Fax:** __________ **Email:** __________

☐**Registered Owner** ☐**Partner** ☐**Officer** ☐**Director** ☐**Controlling Shareholder**

Applicant Name: ______________________________

Business Address: ______________________________
Street City State Zip

Phone: __________ **Fax:** __________ **Email:** __________

☐**Registered Owner** ☐**Partner** ☐**Officer** ☐**Director** ☐**Controlling Shareholder**

Applicant Name: ______________________________

Business Address: ______________________________
Street City State Zip

Phone: __________ **Fax:** __________ **Email:** __________

☐**Registered Owner** ☐**Partner** ☐**Officer** ☐**Director** ☐**Controlling Shareholder**

Stanislaus County
Emergency Medical Services Agency

Attachment C
Signed Declaration Statement

Please sign and date the following declaration statement:

I declare under penalty of perjury and the laws of the State of California, that the information contained in this application is accurate and true to the best of my knowledge. I am aware that should any of the information be found false, the affected County and/or Stanislaus County EMS Agency may pursue any remedy authorized by law, which shall include the right, at the option of the County and/or Stanislaus County EMS Agency, of declaring any agreement made as a result there of to be void.

Date

Printed Name

Signed Name