NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Services and Trauma Systems

Application for New Service, Expansion of Primary Operating Territory or Transfer of Ownership

Application for (check one)

- ☐ New service (Sections A,B,C,D,F)
- ☐ Expansion of Primary Operating Territory for existing service (Sections A,B,C,D,F)
- ☐ Transfer of existing service operating authority (Sections A,D,E,F)

Type of Service (check one)

- ☐ Ambulance
- ☐ ALS First Responder

Section A Organizational Structure

For a corporation, attach a copy of certificate of incorporation, any DBAs and a listing of all owners' stockholders, principals, investors and/or parent corporations or sub-corporations. For LLC attach a copy of NYS DOS Application For Authority.

Name of Service | DOH Agency Code | Federal Employer Identification Number

Address | City | State | Zip | County

Contact Person | Title

Business Phone ( ) - | Home Phone ( ) - | Cell Phone ( ) - | E-mail

Current Organizational Sponsor Type

- ☐ Proprietary
- ☐ Hospital Based
- ☐ Volunteer Independent
- ☐ Industrial
- ☐ Volunteer Fire Department
- ☐ Municipal/Government
- ☐ Other _____

Type of Ownership

- ☐ Individual
- ☐ Partnership
- ☐ Government
- ☐ Corporation
- ☐ LLC

Name of Individual Owner, Partners, Corporation or Government Entity (attach a listing of any/all owners of 10% or more stock)

Section B Primary Operating Territory

Specify geographic area requested using municipal, political or other identifiable Boundaries. Attach a detailed map of the primary service area. Statements such as "surrounding, adjacent, vicinity, proximity, contiguous, adjoining, or portions of, etc." are not acceptable when defining a primary operating territory.

Proposed new or expanded primary operating territory

For expansion list existing primary operating territory

Section C Financial Responsibility

Applicant is required to attach detailed fiscal and budgetary information as specified in the current DOH Policy Statement. An initial start-up or continuation budget and sufficient financial information as well as the source of such must be provided to insure the fiscal responsibility and stability of the ownership for the territory served.

Insurance Carrier

Agent | Business Phone ( ) -

Types and Limits of Coverage ☐ General Liability ☐ Other _____

Section D Description of Proposed Services

For a corporation attach a certificate of incorporation, any DBAs and a listing of all owners, stockholders or principals.

Level of Service (check only one)

☐ EMT ☐ AEMT ☐ Critical Care ☐ Paramedic

Agency Medical Director	Address	City	State	Phone Number ( ) -
Agency Providing Medical Control				Phone Number ( ) -
System Medical Director	Address	City	State	Phone Number ( ) -

Size of Population to be Served | Days of operation | Hours of operation

Projected Call Volume | Total _____ | Emergency _____ | Non-Emergency _____

Source of Statistics for Call volume ☐ PCR ☐ Dispatch Center ☐ Agency Call Record ☐ Other _____

Total no. of ambulances | Total no. of emergency ambulance service vehicles (EASV'S) | Total no. of ALS First Response vehicles

Section E Proposed Organizational Structure

For a corporation attach a copy of certificate of incorporation for any DBAs listing of all owners' stockholders, principals, investors and/or parent corporations or sub-corporations. For LLC attach a copy of NYS DOS Application For Authority.

Proposed Name of Service | Federal Employer Identification Number

Address | City | State | Zip | County

Contact Person | Title

Business Phone ( ) - | Home Phone ( ) - | Cell Phone ( ) - | E-mail

Proposed Organizational Sponsor Type

☐ Proprietary ☐ Hospital Based ☐ Volunteer Independent ☐ Industrial
☐ Volunteer Fire Department ☐ Municipal/Government ☐ Other _____

Proposed Type of Ownership

☐ Individual ☐ Partnership ☐ Government ☐ Corporation ☐ LLC

Name of Proposed Individual Owner, Partners, Corporation or Government Entity (attach any/all owners of 10% or more stock)

Section F Certification of Accuracy and Ownership Competency

As owner/CEO/operator of the ambulance service described herein I attest to the accuracy of the information contained in this application and its attachments and to having received and read Public Health Law Article 30 and State EMS Code Part 800. I also state that neither the corporation nor any of the owners, principals or stockholders in the corporation, or LLC members, have been convicted of Medicare or Medicaid fraud. I understand that under Section 3012(a) of the PHL Article 30 that the ambulance service or ALS FR service certificate for this agency may be revoked, suspended limited or annulled if this application includes willful misrepresentation.

Attachments Required

- Detailed narrative to support need or statement of purpose and intent for transfer
- Affirmation of Fitness and Competence (DOH-3778)
- DOS Certificate of Incorporation or Authority, DBA's, owners, partners, shareholders or members listing
- Financial information including funding budget and insurance
- Primary operating territory map

Name of Owner or CEO | Title

Signature | Date

Notary Public affirmation and acknowledgement

FOR REGIONAL EMS COUNCIL USE ONLY

Date Application Received _____

Date of Council Decision _____

☐ Approved ☐ Denied ☐ Rejected – Incomplete

Council Chair Signature _____