

LINCOLN COUNTY
Emergency Medical Services



Application for Franchise



"Committed to Improving the Health & Safety of Our Community"

Lincoln County Emergency Medical Services
720 John Howell Memorial Drive • Lincolnton • North Carolina • 28092
Phone: (704) 736-9385 • Fax (704) 736-1924

**LINCOLN COUNTY
DEPARTMENT OF EMERGENCY MEDICAL SERVICES
APPLICATION FOR PROVIDER FRANCHISE**

The Lincoln County Emergency Medical Services Ordinance, dated 06 March 2007, requires that any person, firm, corporation, or organization have a valid Franchise Agreement issued by the Lincoln County Board of Commissioners to treat or transport patients in Lincoln County.

Basic Life Support Provider

All vehicles to be permitted for this provider shall meet the minimum requirements per design and function as listed in 10 NCAC 3D, for approval under this application.

Advanced Life Support Provider

All vehicles to be permitted for this provider shall meet the minimum requirements for equipment as listed in 10 NCAC 3D, and 10 NCAC 3M, for approval under this application.

The application materials shall be reviewed for recommendation by the Lincoln County Emergency Medical Services Peer Review Committee and final approval granted by the Chairman, Lincoln County Board of Commissioners.

This application is intended to be self-explanatory. As a result of accommodations for all possible situations, some questions and/or attachments may not be applicable. Please attach only applicable information.

Submissions are required ninety (90) days prior to implementation and/or renewal. **One (1) original and one (1) copy are requested.** Completed applications and further inquiries are to be directed to:

Lincoln County Emergency Medical Services
ATTN: System Administrator
720 John Howell Memorial Drive
Lincolnton, North Carolina 28092

Phone: 704-736-9385 Office
Fax: 704-736-1924

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I. PROVIDER INFORMATION

Application Date: _____ Initial [] Renewal []

Legal Name of Provider: _____

Mailing Address: _____

Legal Owner(s): _____

Contact Person: _____

Contact Person Title: _____

Phone Number: _____ Fax Number: _____

E-Mail: _____

NCOEMS Provider Number: _____ NCDOI FDID: _____

If this applicant is currently licensed by the North Carolina Office of Emergency Medical Services, list the following:

License Number: _____ Level of Certification: _____

Date of Issuance: _____ Expiration Date: _____

Attach a certified copy of an assumed name certificate or articles of incorporation, if applicable (Attachment 1)

Summarize the training and experience of your organization in the care and/or transportation of patients. (Attachment 2)

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II. DESCRIPTION OF SERVICES

(Attach additional copies of this page for each service area in which you will be providing service.)

1. Description of service area to include square miles:

2. Indicate your proposed level of operation (check all that applies).

All levels require a minimum of ten (10) active members of your organization that maintain in a current status the level of certification requested. Franchised departments shall be automatically dispatched to the call types listed below.

AED Responder Agency: AHA Basic Cardiac Life Support-Healthcare Provider
• Dispatched to all ECHO level medical calls

AED Plus Responder Agency: NC EMT-Basic and AHA BCLS-Healthcare Provider
• Dispatched to all ECHO level medical calls and may self dispatch only if EMT-Basic is available to respond with appropriate equipment

EMT-Basic Responder Agency: NC EMT-Basic and AHA BCLS-Healthcare
• Dispatched IAW current EMD Response Codes published by LCEMS

Other: _____

3. Will this service be provided 24 hours per day/7 days per week by this Provider? Yes (If Yes, Go to item 4) No (If NO, complete below)

Day(s) of Operation:

Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday
 Sunday

Hours of Operation:

From: _____ To: _____
From: _____ To: _____

4. If charges for services rendered are to be made, attach a complete schedule of charges. (Attachment 3)

5. Please explain in detail how you as the provider will assure that adequate certified personnel will be available to respond to all calls (Attachment 4).

6. Indicate the manpower breakdown by North Carolina and National Certifications. (Attach a current manpower roster with full name, address, e-mail address, telephone number, social security, certification numbers, certification level, expiration dates and a copy of all current certifications.) (Include Provider Verification Form for each individual provider) (Attachment 5)

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7. Indicate the level at which you propose to operate your ambulances.

- Not Applicable (If N/A, Go to item 9)
- Convalescent Transport
- EMT-Basic
- EMT-Intermediate
- EMT-Paramedic

8. Indicate the number of permitted/proposed permitted apparatus .

- Convalescent Transport
- Ground Ambulance
- Critical Care Transport Ambulance

Are the above vehicles currently permitted? YES NO

If NO, present evidence of the intent to apply for a NCOEMS permit for all apparatus which will be in service as required by G.S. 131E-156. (Attachment 6)

Attach a current listing of all apparatus which will be in service for medical responses with unit identification number, VINV, make, model, manufacturer, description and year of manufacture. (Attachment 7)

9. Indicate the number of proposed **non-permitted** apparatus that may respond to medical calls.

- Brush Truck
- Engine
- Squad
- Ladder

Rescue Apparatus

Other(s): _____

Attach a current listing of all apparatus which will be in service for medical responses with unit identification number, VINV, make, model, manufacturer, description and year of manufacture. (Attachment 8)

10. Do you currently have in place a written standard operating guideline for the systematic and periodic inspection, repair and maintenance of permitted apparatus and equipment? YES NO (Attachment 9)

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11. Do you currently have in place a written standard operating guideline for emergency vehicle operations? N/A YES NO (Attachment 10)

12. Do you currently have in place a written standard operating guideline for infection control / exposure control procedures? N/A YES NO (Attachment 11)

13. Attach an 8 1/2 x 11 map indicating the service area, base(s), and locations of medical response apparatus. List the complete address and phone number of each location. (Attachment 12)

III. SIGNATURE OF REQUESTER

We, the undersigned, have reviewed this complete Provider Franchise Application and attachments. We fully endorse this Franchise with a thorough understanding of our respective roles and responsibilities in maintaining a provider franchise in the county of Lincoln pursuant to the Lincoln County Emergency Medical Services Ordinance, dated 06 March 2008.

To the best of our knowledge, all information provided herein is true and accurate.

Please type or print the names of signers directly below each signature.

Date

Provider Administrator

Date

Provider Chairman/President/Owner
Board of Directors

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IV. REVIEW AND RECOMMENDATION

We, the undersigned, have reviewed this completed Provider Franchise Application and attachments. We recommend this application for approval / disapproval as indicated below.

Please type or print the names of signers directly below each signature.

		Recommendation
<hr/>	<hr/>	[] Approve [] Disapprove
Date	Inga Kish, MD Chairman, Lincoln County Quality Management Committee	Level: _____
<hr/>	<hr/>	[] Approve [] Disapprove
Date	Ronald D. Rombs Director, Lincoln County Emergency Medical Services	Level: _____
<hr/>	<hr/>	[] Approve [] Disapprove
Date	County Manager	Level: _____

V. OFFICIAL ACTION OF REQUEST

The Board of Commissioners of the county of Lincoln through appropriate action, (please circle) **Approve** / **Disapprove** this request for franchise as presented this _____ day of _____ 20 _____.

Chairman
Board of Commissioners

ATTEST:

Amy Atkins
Clerk to the Board