



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
Office of Emergency Medical Services



**PRIMARY SERVICE AREA RESPONDER APPLICATION**

This application is to be completed fully by the applicant. You are strongly encouraged to contact your Regional EMS Coordinator for any assistance you may require in completing this application.

***NOTE: Local EMS Planning is the responsibility of the municipality and any affected municipality should be included in discussions regarding modifying EMS resource deployment or system design.***

The Office of Emergency Medical Services shall, in consultation with the appropriate Regional Council(s), review the application for completeness. It shall be the sole responsibility of the Office of Emergency Medical Services to deem the application complete. Requests for additional information shall be forwarded to the applicant within thirty (30) days of the receipt of the application. The applicant shall provide such requested additional information within ten (10) business days of the receipt of such request. The Regional Council(s) shall have forty-five (45) days after receipt of an application to forward a recommendation to the Office of Emergency Medical Services. The Office of Emergency Medical Services shall render a decision on the application within ten (10) business days after receipt of the Regional Council(s) recommendation. The above time lines may be waived by mutual agreement.

**REQUIRED ATTACHMENTS**

A letter of support from the Chief Elected Official of the municipality in which the PSA lies.

A letter of support from the Chief Executive Officer of the EMS Organization in which the PSA lies.

Certificate of Insurance Forms:

- Proof showing General or Public Liability Insurance
- Malpractice Insurance (also known as Professional Liability)

Submit the original application (including all required attachments) to the address below, to the attention of the [Regional EMS Coordinator](#).

*Please remember to retain a copy for your records.*

**Department of Public Health  
Office of Emergency Medical Services  
410 Capitol Avenue, MS#12EMS  
PO Box 340308  
Hartford, CT 06134-0308  
(860) 509-7975**



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



APPLICATION FOR PRIMARY SERVICE AREA
RESPONDER (PSAR) ASSIGNMENT

PROVIDER INFORMATION

1. Name of Service: \_\_\_\_\_

2. Street Address: \_\_\_\_\_

\_\_\_\_\_

3. Mailing Address: \_\_\_\_\_

\_\_\_\_\_

4. Telephone Numbers: Business: \_\_\_\_\_

Emergency: \_\_\_\_\_

FAX: \_\_\_\_\_

5. Chief Executive Officer: Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone \_\_\_\_\_

6. Contact Person Name \_\_\_\_\_

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.

FOR OEMS USE ONLY

Table with 3 columns: NUMBER, DATE RCVD, RC REVIEW COMPLETE; DEEMED COMPLETE | DATE, OEMS DIRECTOR SIGNATURE



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



APPLICATION FOR PRIMARY SERVICE AREA
RESPONDER (PSAR) ASSIGNMENT

PROVIDER INFORMATION (CONT)

7. Type of PSAR Assignment Requested (select all that apply):

- First Responder
Basic Ambulance
Mobile Intensive Care – Advanced
Mobile Intensive Care - Paramedic

Is the PSA assigned at the First Responder level? yes no

If "yes" is checked, enter name of First Responder PSAR:

\_\_\_\_\_

Is the PSA assigned at the Basic Ambulance level? yes no

If "yes" is checked, enter name of Basic Ambulance PSAR:

\_\_\_\_\_

Is the PSA assigned at the MIC-A or MIC-P level? yes no

If "yes" is checked, enter name of MIC-A or MIC-P PSAR:

\_\_\_\_\_

8. Type and Number of vehicles to be equipped:

- Number of transporting EMS vehicles:
Number of non-transporting EMS vehicles:
Total:

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
Office of Emergency Medical Services



---

**EFFECT OF PROPOSED ASSIGNMENT**

Please provide a narrative description of how the primary service area responder service will function. Include at least the following information:

- 1) a description of the need for the applicant primary service area responder level of service;
- 2) how the applicant primary service area responder will interact and integrate with existing providers in the proposed service area; and
- 3) how the designation of the applicant as primary service area responder will improve patient care in the Primary Service Area to be served. Attach additional pages if necessary.

**Note: Please do not leave required fields blank, enter "N/A" if it does not apply.**





STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



ACTIVATION TIME

This section should include the following information:

- 1. Name of EMS Dispatch Agency:
2. Description of communications equipment that will activate EMS provider organization personnel:

3. Activation time information:

“Activation time” means the measure of time from notification to the EMS provider organization that an emergency exists, to the beginning of the response of EMS provider organization personnel. Please provide activation time data for the twelve (12) months preceding the submission of this application in the “fractile” format listed below.

Activation Time Fractile Data:

From: mo / day / yr To: mo / day / yr Based on total responses

Percentage of Responses where activation time was:

- Less than or equal to one minute: %
Greater than one minute but less than or equal to two minutes: %
Greater than two minutes but less than or equal to three minutes: %
Greater than three minutes but less than or equal to four minutes: %
Greater than four minutes: %
Total: %

4. If activation time data for the preceding twelve months does not exist, please describe the plan for collecting fractile activation time data (attach additional page if necessary).

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.



**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
 Office of Emergency Medical Services



**RESPONSE TIME AND TWENTY-FOUR HOUR COVERAGE**

1. Estimated annual call volume: \_\_\_\_\_
2. Fractile Response time data:

“Response Time” means the total measure of time from notification to the EMS provider organization that an emergency exists, to arrival at the patient’s side (including the activation time). Please provide response time data for the twelve (12) months preceding the submission of this application in the “fractile” format listed below.

From: \_\_\_\_\_ To: \_\_\_\_\_ Based on \_\_\_\_\_ total responses  
 mo / day / yr mo / day / yr

Percentage of response times that were:

- Less than or equal to four minutes: \_\_\_\_\_ %
- Greater than four minutes but less than or equal to five minutes: \_\_\_\_\_ %
- Greater than five minutes but less than or equal to six minutes: \_\_\_\_\_ %
- Greater than six minutes but less than or equal to seven minutes: \_\_\_\_\_ %
- Greater than seven minutes but less than or equal to eight minutes: \_\_\_\_\_ %
- Greater than eight minutes: \_\_\_\_\_ %
- Total: \_\_\_\_\_ %

3. Staffing Plan - describe the staffing plan that will assure 24/7/365 basis.

4. If response time data for the preceding twelve months does not exist, please describe the plan for collecting fractile response time data on an additional narrative page.

**Note: Please do not leave required fields blank, enter "N/A" if it does not apply.**







STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



VEHICLE INFORMATION

This section should include the following information for each vehicle to be utilized by the applicant (copy this page and attach for additional vehicles):

Vehicle Make: \_\_\_\_\_

Chassis: \_\_\_\_\_ Year: \_\_\_\_\_

Classification: \_\_\_\_\_

Vehicle ID Number (VIN): \_\_\_\_\_

Marker Number: \_\_\_\_\_

Vehicle Make: \_\_\_\_\_

Chassis: \_\_\_\_\_ Year: \_\_\_\_\_

Classification: \_\_\_\_\_

Vehicle ID Number (VIN): \_\_\_\_\_

Marker Number: \_\_\_\_\_

Vehicle Make: \_\_\_\_\_

Chassis: \_\_\_\_\_ Year: \_\_\_\_\_

Classification: \_\_\_\_\_

Vehicle ID Number (VIN): \_\_\_\_\_

Marker Number: \_\_\_\_\_

Note: Please do not leave required fields blank, enter "N/A" if it does not apply.



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
Office of Emergency Medical Services



**CHIEF ADMINISTRATIVE OFFICIAL’S RECOMMENDATION**

*Section 19a-179-4 (b) of the Regulations of Connecticut State Agencies states that prior to the assignment of a Primary Service Area, OEMS shall solicit the advice and recommendation of the appropriate regional council and the chief administrative official of the municipality in which the PSAR lies.*

The chief administrative official (or officials) of the municipality (or municipalities) in which the proposed primary service area lies should complete this page of the application.

NAME (please print): \_\_\_\_\_

TITLE: \_\_\_\_\_

MUNICIPALITY: \_\_\_\_\_

I recommend that OEMS:  
    approve  
    not approve  
this application for Primary Service Area Responder designation.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Note: Please do not leave required fields blank, enter "N/A" if it does not apply.**



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
Office of Emergency Medical Services



**SIGNATURE PAGE**

The Chief Executive Officer of the proposed service must read and sign this page.

\_\_\_\_\_  
Name of applicant service

I do hereby warrant and certify that the above-named EMS provider organization shall carry out its responsibilities in accordance with Section 19a-179-4(a) of the Regulations of Connecticut State Agencies.

All information provided within this application is, to the best of my knowledge, true and correct.

\_\_\_\_\_  
Chief Executive Officer

\_\_\_\_\_  
Date

**Note: Please do not leave required fields blank, enter "N/A" if it does not apply.**