



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
67 Forest Street, Marlborough MA 01752

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Governor

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Lieutenant Governor

MARYLOU SUDDERS
Secretary

MARGRET R. COOKE,
Acting Commissioner
Tel: 617-624-6000
www.mass.gov/dph

**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 ambulance service. The application must be received by the Department of Public Health (Department) at least 30 calendar days prior to anticipated commencement of Community EMS Program operations.

Unless indicated otherwise, all responses must be submitted in the format specified. Handwritten responses or attachments will not be accepted.

Attachments should be labeled or marked so as to identify the question to which they relate.

REVIEW

Applications are reviewed in the order they are received.

After a completed application is received by the Department, the Department will review the information and will contact the applicant if clarifications or additional information for the submitted application materials are needed.

If the applicant does not receive a response from the Department within 30 calendar days of its receipt of the completed application, the applicant may commence operations.

REGULATIONS

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

QUESTIONS

If additional information is needed regarding the Community EMS Program application process, please contact the MIH Program at 781-675-0478 or MIH@mass.gov.

APPLICATION ATTACHMENT CHECKLIST

- ☐ This application and all required attachments.
- ☐ Letter of support from the authorized signatory of the local jurisdiction, if signature on this application could not be completed. Submission should be on official letterhead of jurisdiction.
- ☐ For anyone who wants to propose adding a service to the Defined List of Community EMS Program Services, a Petition for Addition of, or Exclusion from, the Defined List of Community EMS Program Services form must be completed. Applicants may not apply for a Community EMS program that intends to provide services outside of the current Defined List of Community EMS Program Services without a petition. The timeframe for consideration of petitions by DPH is not limited to 30 calendar days.
- ☐ 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 last page of the previous application if it was saved
Previous Application Number: _____

To submit this application and all required supporting documentation, please fax the documents to **617-887-8751**. Applicants must label all supporting documents with the 14-digit application number found on the last page of this application. Please attach all required supporting documents.

1. APPLICANT INFORMATION

Date:

Ambulance Information	
For each local jurisdiction covered by the proposed program, the primary ambulance service must be included. Please list below the ambulance license number, contact name and title, telephone number, and email address as applicable. You may enter multiple values as applicable in the space provided below.	
Primary Ambulance Service Name	
Applicable Local Jurisdiction(s)	
Ambulance License Number	
Ambulance Contact Name	
Title	
Telephone Number	
Email Address	
Total EMS Personnel FTEs in Proposed Program	
Total Paramedic FTEs in Proposed Program	
Operationally Affiliated Health Care Organizations	
Program Funding	<input type="checkbox"/> Agency funds/tax revenue <input type="checkbox"/> Grant support <input type="checkbox"/> 3 rd party payers <input type="checkbox"/> Other (describe):
Proposed Program Start Date	

Affiliate Hospital Medical Director Information	
Name of Primary Ambulance Service's Affiliated Hospital Medical Director	
Title	
Telephone Number	
Email Address	

Local Public Health Authority (LPHA) Information			
Name of Local Public Health Authority			
Address of Local Public Health Authority			
	Street		
	City	State	Zip Code
Local Public Health Authority Contact Name			
Title			
Telephone Number			
Email Address			
Name of LPHA Authorized Signatory			
* Signature of LPHA Authorized Signatory			
Date of Signature			

* Please refer to the instructions document on how to create an e-signature located at:
www.mass.gov/MIH

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.

Attestation for Local Jurisdiction only. Attach a letter of support from Local Jurisdiction authorized signatory if signature cannot be obtained.

I am duly authorized to approve this application on behalf of the City/Town of: _____

Signature of Local Jurisdiction Authorized Signatory

Date Signed

Print Name Local Jurisdiction Authorized Signatory

Title of Local Jurisdiction Authorized Signatory

Signature of Local Public Health Authority Authorized Signatory

Date Signed

Print Name Local Public Health Authority Authorized Signatory

Title of Local Public Health Authority Authorized Signatory

Signature of Affiliated Hospital Medical Director

Date Signed

Print Name of Affiliated Hospital Medical Director

Title of Affiliated Hospital Medical Director

2. PROGRAM OVERVIEW

- a. Please attach a description of 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; and
 - iv. All operational partnerships involved

3. SERVICES PROVIDED

a. Indicate below 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 Community EMS services online. If additional space is required please attach a separate document.

Note: Applicants may only apply to become a Community EMS program proposing services that are included in the Defined List of Community EMS Program Services. For any service not contained on such list, individuals must separately submit a Petition for Addition of, or Exclusion from, the Defined List of Community EMS Program Services form, which includes written request including a description of the service with appropriate supplemental evidence supporting the future inclusion in the Defined List of Community EMS Program Services. The timeframe for consideration of petitions by DPH is not limited to 30 calendar days.

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 Personnel 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.

Signature of Local Public Health Authority Authorized Signatory

Date Signed

Print Name of Local Public Health Authority Authorized Signatory

Title of Local Public Health Authority Authorized Signatory

- 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.
 - iv. Ensure vehicles deployed by the primary ambulance service partner are appropriate for the clinical encounter, and that all regulatory and manufacturer requirements specific to equipment, supplies and medications will be adhered to when responding to a Community EMS encounter.
 - v. Ensure that the 911 EMS system will be activated and that the Community EMS on-scene personnel 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 in coordination with medical direction indicates to on-scene personnel that the patient is experiencing a medical emergency.

Signature of Affiliate Hospital Medical Director

Date Signed

Print Name of Affiliate Hospital Medical Director

Title of Affiliate Hospital Medical Director

Document ready for Filing

1. When document is complete click on "Document is ready to submit". This will generate an application number, lock the responses, generate today's date and time-stamp the form.
2. Please keep a copy for your records by clicking on the "Save" button at the bottom of the page.

This document is ready to submit: ☐ Date:

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

Save

Print

Reset

3. To submit this application and all required supporting documentation, please fax the documents at **617-887-8751**. Applicants must label all supporting documents with the 14-digit application number found on this page as above (in red) once application is completed.