



TEXAS
Health and Human
Services

Texas Department of State
Health Services

**EMS PROVIDER RENEWAL
WITH FEE PAYMENT**

Revised 06/2017

For DSHS Use Only - ZZ100-160

Remit Date _____

Remit No. _____

Amount Pd. _____

EMS PROVIDER APPLICANT ADDRESSING INFORMATION: When sending EMS Provider/FRO Licensing submissions **that contain a fee payment**, please send to the appropriate address:

<u>General Mail (US Mail):</u>	<u>Overnight/Express/Parcel:</u>
Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 PO Box 149347 Austin, Texas 78714-9347	Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 1100 West 49 th St. Austin, Texas 78756-3101

Payment Submitted by (if different than applicant):	
Name of EMS Provider or FRO applicant:	
EMS Provider License Number:	
Applicant's Assumed Name or DBA (if applicable):	
Mailing Address:	
City, State, Zip:	
Payment Amount:	
Submission Date:	

If sending a USB drive, please insure the USB drive is securely fastened to a letter addressed to EMS Certification and Licensing Group, in case it is separated from the envelop in the mail room.

**INTERNAL DSHS DELIVERY:
EMS Certification
Exchange Building – MC 2835**



As per 25 TAC, §157.11, EMS providers are responsible to submit to the Department of State Health Services any of the following notifications and/or changes within the time stated:

Submit this completed form along with the appropriate cover sheet. Cover sheets contain the mailing/shipping address this form should be sent to and can be found at www.dshs.state.tx.us/emstraumasystems/provfro.shtm.

Fax Number: 512-834-6714 Email: EMSProviderFRO@dshs.texas.gov

EMS Provider Information

Name of Legal Entity, Legal Entity Assumed Name, Entity Address, City, State, Zip, County, License Number, Phone, Fax

Medical Director Change - within 1 business day

New Medical Director Name, License Number, Resignation/Termination Date of Previous, Reason for Change, Required Additional Documentation (All required): Attach Medical Director Information Form, Attach Medical Director Agreement/Contract, Attach electronic copy (CD or USB Flash Drive) of New Protocols and Equipment/Medication List.

Change in Declared EMS Administrator of Record (AOR) - within 5 business days

Do not submit this form for a name change request, please submit a Personnel Name Change Form. Previous Administrator's Name, SSN/EMS Certification #, New Administrator's Name, SSN/EMS Certification #, E-mail, Business Phone, Effective Date, Required Additional Documentation: Attach EMS Provider Administrator of Record Information Form (Government Entities exempt).

Delete EMS Vehicle(s)

Unit#, VIN #, Required Additional Documentation: Return the original vehicle authorization with this form (Certificate that is placed in vehicle).

Add EMS Vehicle(s)

Required Additional Documentation (All required unless noted otherwise):

- Attach EMS Vehicle Form with only new vehicle(s) information.
- Attach Updated EMS Personnel Form, revised staffing plan and revised service area map (if applicable).
- Attach Certificate of Insurance for all EMS Vehicles operated by the provider.
- Attach Copy of vehicle title, vehicle lease agreement, registration receipt from the DMV, exempt registrations if applicant is a government subdivision, or an affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.
- Enclose Payment of \$180 per additional vehicle for license with more than 12 months remaining before expiration date or \$90 per additional vehicle for license with 12 months or less remaining before expiration date.
- Requesting Fee Exemption. Must complete Fee Exemption section on this form.

EMS Vehicle Substitution or Replacement - within 5 business days

Old Vehicle: Unit# _____ VIN # _____ Type ___ LP _____ Make _____ Year _____

New Vehicle: Unit# _____ VIN # _____ Type ___ LP _____ Make _____ Year _____

Reason for Change: _____

Old Vehicle: Unit# _____ VIN # _____ Type ___ LP _____ Make _____ Year _____

New Vehicle: Unit# _____ VIN # _____ Type ___ LP _____ Make _____ Year _____

Reason for Change: _____

Required Additional Documentation (All required unless noted otherwise):

- Attach Certificate of Insurance for all EMS Vehicles operated by the provider.
- Attach EMS Vehicle Substitution/Replacement Form found at the end of this document **if replacing more than two vehicles.**
- Attach Copy of vehicle title, vehicle lease agreement, registration receipt from the DMV, exempt registrations if applicant is a government subdivision, or an affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.

Notification of Collision Involving In-Service and/or Response Ready EMS Vehicle - within 1 business day

If there was a collision that resulted in vehicle damage whenever there was personal injury or death to any person.

Location of Accident _____ Date of Accident _____

Notification of Collision Involving In-Service and/or Response Ready EMS Vehicle - within 5 business days

If a vehicle was rendered disabled and inoperable at the scene or there is a patient on board.

Location of Accident _____ Date of Accident _____

Change of Vehicle Authorizations – Must be approved for the level you want to change to.

Authorization Level Changing From _____ Authorization Level Changing To _____

Number of authorizations being changed _____

Required Additional Documentation:

- Enclose Payment of \$10 per authorization being changed and reprinted.
- Requesting Fee Exemption. Must complete Fee Exemption section on this form.

Change in Address of Physical Location

Previous Address _____
Phone Number _____ Fax Number _____
New Address _____
Phone Number _____ Fax Number _____
Effective Date _____

Change in Mailing Address

Previous Address _____
Phone Number _____ Fax Number _____
New Address _____
Phone Number _____ Fax Number _____
Effective Date _____

Change in Address for Location of Patient Report File Storage

Previous Address _____
Phone Number _____ Fax Number _____
New Address _____
Phone Number _____ Fax Number _____
Effective Date _____

Change in Billing Address

Previous Address _____
Phone Number _____ Fax Number _____
New Address _____
Phone Number _____ Fax Number _____
Effective Date _____

Change in Dispatch Address

Previous Address _____
Phone Number _____ Fax Number _____
New Address _____
Phone Number _____ Fax Number _____
Effective Date _____

Upgrade or Downgrade in Level of Service - within 5 business days

This only applies if provider is not currently approved to operate at the new level of service

Previous Level of Service _____ New Level of Service _____ Desired Effective Date _____

Required Additional Documentation (All required unless noted otherwise):

- Attach Protocols (CD or USB Flash Drive) for review.
- Attach Equipment/Medication List (CD or USB Flash Drive) for review.
- Attach Updated Employee Form for review (if upgrading).
- Attach Updated EMS Vehicle Form.
- Enclose Payment of \$30 for each vehicle being changed to a new level of service.
- Requesting Fee Exemption. Must complete Fee Exemption section on this form.

Change in Declared Service Area - within 5 business days

Does EMS Provider provide 911 Service? Yes No

Will this Change affect 911 Service? Yes No

If yes, will the EMS Provider continue to provide 911 service in any service area? Yes No N/A

Required Additional Documentation (All required unless noted otherwise):

- Attach 911 Service Area contract (if applicable)
- Description of new service area is attached (City & County).
- Attach List of Station Locations: Station Additions Station Deletions
- Does this change affect the Protocols? Yes No Attach Protocols (if applicable)

Subscription Services: Notification of Advertisements - within 10 days after beginning of any enrollment period

Attach Copy of advertisement. Enrollment Period Date _____

Requesting Fee Exemption – Only complete this section if provider is exempt from fees Government Entities cannot claim fee exemption

I, _____, certify that the above named entity meets the following provisions of 25 TAC, Chapter 157: 1) provides emergency pre-hospital care, 2) operates with at least **75% volunteer personnel**, 3) have no more than **five full-time paid staff or equivalent** and 4) the firm is recognized as a **Section 501 (c) (3) nonprofit corporation by the Internal Revenue Service**.

Name and Signature of Applicant, Owner or Authorized Agent, Date

On behalf of the above named legal entity, to the Texas Department of State Health Services, I hereby affirm and declare that all information submitted on this form and attached supplemental documents are true and correct. It is understood that any false information given or misrepresentation made in this application or other requested documents may result in revocation or denial of license. I have read, understand, and agree to abide by Chapter 773 of the Texas Health and Safety Code and Title 25 of the Texas Administrative Code, Chapter 157.

Signature of Applicant, Owner or Authorized Agent

Printed Name of Applicant/Authorized Agent/ Title
(Must be owner if a change in EMS Administrator)

Email Address _____

Date: _____

Phone: _____

PRIVACY NOTIFICATION

With a few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for information on Privacy Notification. (Reference Government Code, Section 552.021, 552.023 and 559.004)



As per 25 TAC, §157.11, EMS providers are responsible to submit to the Department of State Health Services any of the following notifications and/or changes within the time stated:

EMS Vehicle Substitution or Replacement (within 5 business days)

- 1. Attach Certificate of Insurance for all EMS Vehicles operated by the provider.
2. Attach EMS Vehicle Substitution/Replacement Form more than one vehicle.
3. Attach Copy of vehicle title or vehicle lease agreement or exempt registrations if applicant is a government subdivision or affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.

Old Vehicle: Unit# VIN # Type LP Make Year
New Vehicle: Unit# VIN # Type LP Make Year
Reason for Change:

Old Vehicle: Unit# VIN # Type LP Make Year
New Vehicle: Unit# VIN # Type LP Make Year
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