SOUTH DAKOTA DEPARTMENT OF HEALTH

Office of Rural Health / Emergency Medical Services

South Dakota Ambulance Service Licensure / Re-Licensure Application

This application is for the Licensure / Re-Licensure period of **July 1, 2016** through **June 30, 2018**.

Please complete the entire application and return it, along with a **$12.00 check/money order** payable to: South Dakota Office of Rural Health / EMS, by June 15, 2016 to:

Office of Rural Health / EMS
600 East Capitol Avenue
Pierre, South Dakota 57501

It is important that your application is complete. An incomplete application will be returned; thereby causing a delay in licensure / re-licensure. Those applications received after June 15 may result in a period of time that the service would not be licensed, and third party reimbursement agencies may refuse reimbursement for services delivered during this time.

As changes occur in your service for the First and Second Contact Person, Vehicle/Aircraft, EMS & Non-EMS Personnel, and Medical Director, please notify this office as soon as possible.

Thank you, in advance for your prompt attention. If you would like more information or clarification, please call the EMS Office at (605) 773-4031.

South Dakota Ambulance Service Licensing / Re-Licensing Application

Office of Rural Health / Emergency Medical Services

July 1, 2016 - June 30, 2018

☐ **Initial Licensing** ☐ **Re-Licensing** **License Number**

Transport Type

☐ In-State Ground ☐ Out of State Ground ☐ In-State Air ☐ Out of State Air

Service Level/Staffing ☐ ALS ☐ BLS ☐ Full Time ☐ Volunteer ☐ Other

Comments:

_____

_____

_____

Ambulance Service Name (including dba)

Mailing Address

Street Address (for shipping via United Postal Service)

City State Zip + 4

Business Phone Number for Service

Emergency Phone Number to Access Service

E-mail Address

Person Completing Application & Title

Phone Number Fax Number

Primary Contact Person for Service & Title

Work Phone Home Phone Cell Phone

E-Mail Address

Secondary Contact Person for Service & Title

Work Phone Home Phone Cell Phone

E-Mail Address

Medical Director's Name: **SD License Number:**

Address

City State Zip + 4

Work Phone Home Phone Cell Phone

Ambulance Service Data

1. Ambulance Service is owned and operated by: (City, County, Private, etc.)

2. What is the annual payment to your Medical Director? $

4. What are your current charges for ambulance transports?

Loading Fee ALS ALS Loaded Mile Charge

Loading Fee BLS BLS Loaded Mile Charge

Other Charges

5. Do you charge separately for consumable supplies? Yes No

6. Do you bill Medicare for service to eligible recipients? Yes No

7. Do you bill Medicaid for service to eligible recipients? Yes No

8. Do you charge patients the balance of a bill not paid by Medicare, insurance companies, or other 3rd party payers? Yes No

9. The person responsible for the billing and claims process for your service is:

Name

Address

City State Zip + 4

Work Phone Home Phone Cell Phone

Vehicle / Aircraft Information					
Year	Make	Model	VIN (Tail # for AC)	Odometer (ground)	Type (I, II, III) (FW/RW)

Ambulance Service Personnel						
Name	Address	City/State/Zip	Level: EMT, Intermediate, AEMT, Paramedic	Other Level: RN, LPN, EVOC, EMR, MD, etc.	SD Certification or License Number	Expiration Date

Ambulance Service Personnel (continued)						
Name	Address	City/State/Zip	Level: EMT, Intermediate, AEMT, Paramedic	Other Level: RN, LPN, EVOC, EMR, MD, etc.	SD Certification or License Number	Expiration Date

Ambulance Service Personnel (continued)						
Name	Address	City/State/Zip	Level: EMT, Intermediate, AEMT, Paramedic	Other Level: RN, LPN, EVOC, EMR, MD, etc.	SD Certification or License Number	Expiration Date