TEXAS Health and Human Services | Texas Department of State Health Services

EMERGENCY MEDICAL SERVICES
PROVIDER LICENSE
DECLARATION FORM
REVISED: 10/22/2024

Submit the completed form to the appropriate address and with the appropriate cover sheet when mailing or upload with your online renewal application

All Forms Are Available On The EMS-Trauma System Webpage:

http://www.dshs.state.tx.us/emstraumasystems/provfro.shtm

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

Privacy Notification: With a few exceptions, you have the right to request and be informed about information the State of Texas collect 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 more information on Privacy Notification.
(Reference: Government Code, Section 552.021, 552.023 and 559.004)

TYPE OR PRINT IN BLACK INK

Application Type:
☐ **Initial Application** ☐ **Renewal Application** ☐ **Other** _____
Fill in Requested Information:
DSHS License Number:_____(Leave blank if initial application.) **Federal Employer Identification Number:** _____ **National Provider Identifier Number:** _____

Section 1 – Name of Legal Entity Applying for License

Legal Entity Name: _____

Section 2 – Entity Assumed or Operating Name(s), list all if applicable. If applicable, attach copies of all assumed name certificates.

Section 3 – Name(s) to be used on Vehicles If different from Section 1 & 2, a written explanation must be provided.

Section 4 – Chief Executive Officer / Owner or Highest Elected Official (Government)					
Name:					
Title:					
Address:					
City:					
County:		**State**:		**Zip**:	
Phone:		**Email**:			

Section 5 – Administrator of Record					
Name:					
Address:					
City:					
County:		**State**:		**Zip**:	
Phone:		**Email**:			
TX EMS Certification / ID# or SSN:					
Date of Birth:					

☐ A completed EMS Administrator of Record Form is attached or has been included. Government entities are exempt from submitting the additional form.

Legal Entity Name: _____

Section 6 – Alternate Contact The person who can answer questions if administrator is unavailable.					
Name:					
Title:					
Address:					
City:					
County:		**State**:		**Zip**:	
Phone:		**Email**:			

Section 7 – Designated Infection Control Officer					
Name:					
Title:					
Address:					
City:					
County:		**State**:		**Zip**:	
Phone:		**Email**:			

Section 8 – Physician Medical Director Address must be where the physician receives mail.					
Name:					
TX Medical License #:					
Address:					
City:					
County:		**State**:		**Zip**:	
Phone:		**Email**:			

Legal Entity Name: _____

Section 9 – Vehicle Authorizations List the number of vehicle authorizations requested at each level and the total.	
Basic Life Support (BLS)	
BLS with ALS Capability	
BLS with MICU Capability	
Advanced Life Support (ALS)	
ALS with MICU Capability	
Mobile Intensive Care Unit (MICU- Ground)	
Rotor-Wing (MICU)	
Fixed Wing (MICU)	
Specialized	
TOTAL NUMBER OF AUTHORIZATIONS REQUESTED	0

Section 10 – Information

10-A: Entity Type: Check any that apply or explain.

☐ **Governmental Entity**
Please Select Type of Government Entity:
- ☐ City
- ☐ County
- ☐ ESD - Emergency Service District
- ☐ Hospital District
- ☐ State Agency

☐ **Hospital**

☐ **Private**

☐ **Other (Must Explain)** _____

10-B: Tax Status: You must check only one.

☐ **Government Entity** ☐ **For Profit** ☐ **Non-Profit 501c3**

☐ **Other (Must Explain)** _____

Legal Entity Name: _____

10-C: Response Type: *You must check only one.*

☐ **Emergency / 911** ☐ **Non-Emergency / Non-911** ☐ **Both**

10-D: Subscription Program:

Does your organization offer a subscription program? ☐ **Yes** ☐ **No**

*If yes, please submit all required documentation and information. Air Medical Providers are excluded from this requirement.

10-E: Emergency Medical Task Force (EMTF) Participant:

☐ **Yes** ☐ **No** (This is for planning purposes only. Participation not required.)

10-F: Letter of Credit:

Attach a copy of a letter of credit issued by a federally insured bank (FDIC) or savings institution. An emergency medical services provider that is directly operated by a governmental entity is exempt from this section.

Institution Name: _____

Date of Letter: _____

Amount of required credit: (must select one)

☐ $100,000 for the initial license and for renewal of the license on the second anniversary of the date the initial license is issued

☐ $75,000 for renewal of the license on the fourth anniversary of the date the initial license is issued

☐ $50,000 for renewal of the license on the sixth anniversary of the date the initial license is issued

☐ $25,000 for renewal of the license on the eighth anniversary of the date the initial license is issued

☐ Not required, Explain _____

☐ Exempt - Governmental Entity

Legal Entity Name: _____

10-G: Medicaid Provider Surety Bond

EMS providers are required to provide a surety bond as a condition of participation in the Medicaid program and as required by the Texas Health and Humans Services Commission. An EMS provider that is directly operated by a governmental entity is exempt from this section.

☐ **Yes** ☐ **No** ☐ **Exempt (Governmental Entity)**

If No, please explain: _____

Bond Number: _____

Bond Effective Date: _____

Name of institution issuing bond and contact telephone number:

_____

10-H: EMS Personnel:

Compensation Status:

☐ Paid/Non-Volunteer ☐ Volunteer ☐ Mixed (*You may check only one.)*

☐ I attest on behalf of the legal entity mentioned above, that all licensed or certified EMS personnel have completed a juris prudence examination approved by DSHS.

----or ----

☐ I attest on behalf of the legal entity mentioned above, that all licensed or certified EMS personnel have **NOT** completed a juris prudence examination approved by DSHS but will ensure that all EMS Personnel will complete upon the renewal of their EMS Personnel Certification.

10-I: Medicare and/or Medicaid Eligibility

☐ I attest on behalf of the legal entity mentioned above, that the entity, applicant, management staff, medical director and/or employees are not excluded from participation in the Medicare and/or Medicaid program.

Legal Entity Name: _____

10-J: Headquarters/Physical Primary Location:

☐ I attest on behalf of the legal entity mentioned above, that no other licensed EMS Provider is located at the Headquarters/Primary Physical Location Street Address.

☐ I attest on behalf of the legal entity mentioned above, that the entity owns or has a lease agreement for the Headquarters/Primary Physical Location address.

☐ I attest on behalf of the legal entity mentioned above, that the entity understands it must have permission from DSHS to relocate from the Headquarters/Primary Physical Location address prior to moving.

10-K: Medical Equipment:

☐ I attest on behalf of the legal entity mentioned above, that the entity owns or has a lease for all of the medical equipment that will be used.

☐ I attest on behalf of the legal entity mentioned above, that the entity has enough medical equipment so that each vehicle has its own set of medical equipment to operate at the level authorized by DSHS.

10-L: Vehicles:

☐ I attest on behalf of the legal entity mentioned above, that the entity owns or has a lease for all of the vehicles that will be used.

☐ I attest on behalf of the legal entity mentioned above, that the entity and/or management staff understand that authorized vehicles are considered response ready unless the vehicle is designated as being **out of service** using the form provided by the department.

10-M: Medical Records:

☐ I attest on behalf of the legal entity mentioned above, that the entity has a plan for the going out of business to ensure the maintenance of the medical records.

Legal Entity Name: _____

10-N: Knowledge and Experience:

☐ I attest on behalf of the legal entity mentioned above, that the applicant, including its management staff possesses sufficient professional experience and qualifications related to EMS including: having at least one year of experience each in emergency medical dispatch processes, EMS billing processes, medical control accountability, and quality improvement processes for EMS operations.

10-O: Management Staff:

☐ I attest on behalf of the legal entity mentioned above, that the entity and/or management staff have read the Texas Emergency Healthcare Act and the Texas Administrative Code 157.

10-P: Trauma Service Area (TSA) – Regional Advisory Council (RAC):

☐ I attest on behalf of the legal entity mentioned above, that the entity or its management staff participate in a Regional Advisory Council.

10-Q: RESPONSE HOURS OF OPERATION

☐ I attest on behalf of the legal entity mentioned above, the entity provides 24/7/365 of their declared service.

--- OR---

☐ I attest on behalf of the legal entity mentioned above, is **NOT** available 24/7/365 and has written agreements with other EMS providers for coverage of their declared service area and has notified all the emergency service agencies in the designated service area.

10-R: Expansion by an EMS Provider

☐ I attest on behalf of the legal entity mentioned above, that the entity and its management staff understand that an EMS provider is prohibited from expanding operations to or stationing any EMS vehicles in a municipality or county other than the municipality or county from which the provider obtained the letter of approval under until after the second anniversary of the date the provider's initial license was issued, unless the expansion or stationing occurs in connection with:
(A) a contract awarded by another municipality or county for the provision of EMS;
(B) an emergency response made in connection with an existing mutual aid agreement; or (C) an activation of a statewide emergency or disaster response by the department.

Legal Entity Name: _____

10-S: Station Locations:

☐ I attest on behalf of the legal entity mentioned above, the legal entity mentioned above has stations locations.

10–T: Insurance:

☐ I attest on behalf of the legal entity mentioned above, understand that the entity must maintain motor vehicle liability insurance as required under the Texas Transportation Code.

☐ I attest on behalf of the legal entity mentioned above, understand that the entity must maintain professional liability insurance coverage in the minimum amount of $500,000 per occurrence, or as necessary per state law during the license period.

Section 11 – Service Area

Provide the City(s) and County(s) you plan to operate in. If you need more space Please provide all of the required information on a separate piece of paper.
☐ Additional Sheet(s) attached:

1.	**City:**		**County:**	
2.	**City:**		**County:**	
3.	**City:**		**County:**	
4.	**City:**		**County:**	
5.	**City:**		**County:**	
6.	**City:**		**County:**	
7.	**City:**		**County:**	
8.	**City**:		**County:**	

Legal Entity Name: _____

Section 12 –Governmental Recognition

List and attach recognition from governmental entities. This section does not apply to renewal of an emergency medical services provider license or a municipality, county, emergency services district, hospital, or emergency medical services volunteer provider organization in this state that applies for an emergency medical services provider license. If you need more space, please provide all of the required information on a separate piece of paper. Additional Sheet(s) attached: ☐

1.	**City:**		**County:**	
2.	**City:**		**County:**	
3.	**City:**		**County:**	
4.	**City:**		**County:**	
5.	**City:**		**County:**	
6.	**City:**		**County:**	
7.	**City:**		**County:**	
8.	**City:**		**County:**	

Section 13 – Addresses

Headquarters/Physical Primary Location Street Address:

Address:					
City:					
County:		**State:**		**Zip:**	
Telephone #:		**Fax #:**			

Headquarters/Physical Primary Location Business Hours

Please list the days and hours of normal operation or a designated day and time when personnel are present so the public may ask questions.

_____

☐ I attest on behalf of the legal entity mentioned above, these hours are posted for public viewing on the outside of the building.

Legal Entity Name: _____

Business Mailing Address:					
Address:					
City:					
County:		**State:**		**Zip:**	
Telephone #:		**Fax #:**			

Records Location Street Address: ☐ Same as headquarters					
Address:					
City:					
County:		**State:**		**Zip:**	
Telephone #:		**Fax #:**			

Billing Office Street Address: ☐ Same as headquarters					
Billing Agency:					
Address:					
City:					
County:		**State:**		**Zip:**	
Telephone #:		**Fax #:**			

Dispatch Location Street Address: ☐ Same as headquarters					
Dispatching Agency:					
Address:					
City:					
County:		**State:**		**Zip:**	
Telephone #:		**Fax #:**			

Legal Entity Name: _____

Section 14 – Ownership & Type of Legal Entity

Complete the following to indicate the type of legal entity and responsible persons:

☐ **Government Entity** ☐ **Unincorporated Association of People**
☐ **Sole Proprietorship** ☐ **Partnership / General Partnership**
☐ **Corporation** ☐ **Limited Liability Company** ☐ **Limited Partnership**
☐ **Limited Liability Partnership**
☐ **Other *(must explain)*** _____

Please complete this information for all officers, general partners and limited partners of the legal entity. Government Entities should complete this information for the chief elected official (i.e. city mayor or county judge) or appointed officials that are responsible for the entity (i.e. emergency service district or hospital district board members).

Name: _____

Title: _____

Mailing address: _____

City: _____ **State:** _____ **Zip:** _____

Name: _____

Title: _____

Mailing address: _____

City: _____ **State:** _____ **Zip:** _____

Name: _____

Title: _____

Mailing address: _____

City: _____ **State:** _____ **Zip:** _____

☐ **Additional Persons are listed on separate sheet attached.**

Legal Entity Name: _____

Section 15 – Signature Unsworn Declaration

On behalf of the above named legal entity, I hereby affirm and declare I am authorized to make this Emergency Medical Services Provider application and/or declaration and all information submitted on this form and any supplemental documents are true and correct. I attest and understand the legal entity and I are accountable and responsible for the accuracy of all answers and statements on this form. I attest the legal entity listed on this form meets all requirements for the type of license requested. Further, I understand it is a Class A misdemeanor violation of Texas Penal Code Sec. 37.10 to submit a false statement to a governmental agency. I have read and understand Health and Safety Code Chapter 773 and Texas Administrative Code Title 25, Chapter 157, and agree to adhere to those statutes rules, and all other applicable statutes and rules.

_____ _____

Signature of Administrator of Record **Signature of CEO / Owner**

_____ _____

Printed Name of Administrator of Record **Printed Name of CEO / Owner**

My name is _____ , my date of birth is _____

and my address is _____

(Street) **(City)** **(State)** **(Zip Code)**

and _____. I declare under penalty of perjury that the foregoing is true
(Country)

and correct.

Executed in _____ County, State of _____ , on the ___ day of _____ , _____.
(Month) **(Year)**

_____

Signature of Declarant