|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service Name: | License #: | Current Level: | Proposed start date:  | Main Contact:Phone/Email: |

**General Questions – For service level changes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item** | **Suggested Answers** | **Your Answer / Resources** | **General Information** |
| Community need / meeting held? | **Yes, No** |  | You should insure you have community and/or municipality support. |
| What is the proposed change? | **Upgrade or Downgrade** |  | Outline if this is 24/7 or by flex. |
| If downgrade, do you cover more than one municipality? | **Yes, No** |  | If you cover multi areas, you must get a letter of support from all municipalities per DHS 110.37 prior to a downgrade. |
| If upgrade, what is the proposed 911 coverage 24/7 level? | **Proposed level** |  | This is identified in DHS rule: 110.34(5) if providing 911. |
| If upgrade will you be using the Flex staffing model? | **Yes, No** |  | This is separate of flex using EMRs as legal crew. |
| If Flex Staffing, what level? | **Identify what level** |  | You must insure you have adequate equipment available for the proposed level. |
| Have changes been approved by your Medical Director? | **Yes, No** |  | The Medical Director ultimately makes the approval to the level you intend to provide |

**Operational (A template will be available to tally costs where appropriate)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Item** | **Suggested Answers** | **Your Answer / Resources** | **General Information** |
| Level of Service – Current: | **EMR, EMT, AEMT, Paramedic, Interfacility, Intercept** |  | Identify the license level you are currently approved at. |
| Endorsements (if applicable): | **Critical Care, Community EMS or Community Paramedic, TEMS** |  | This is an additional level of service endorsement over base level |
| Proposed Level of Service: | **Include endorsements** |  | Identify the level you are proposing to provide 24/7.  |
| Have you developed a budget? | **A budget worksheet is available** |  | Outlining costs from the beginning will help with future cost estimates. |
| Have you reviewed billing options and allowances? | **Yes, No** |  | You will need approval to bill at a new level, primarily Medicare / Medicaid. |
| If upgrading, do your protocols outline care at those levels? | **Yes, No** | <https://www.surveygizmo.com/s3/6330065/2021-EMS-Protocols-Voluntary-Adoption-and-Attestation>  | Medical Director-approved patient care guidelines must in place prior to upgrade. May use the State of Wisconsin Patient Care Guidelines and completing the attestation survey |
| Will staff be paid? Describe: | **Yes, No, to include, full time, part time, POC, volunteer** |  | Template available to assist with computation of costs; this includes volunteer with stipend or POC |
| Will staff be scheduled? Describe: | **Yes, No, to include, full time, part time, POC, volunteer** |  | 911 coverage requires a staffing schedule for all transporting agencies. |
| Will you provide refresher or internal training? | **Yes, No** |  | Identify a training coordinator and program. Templates available from DHS |
| If yes, will you cover cost and have you identified cost? | **Yes, No** |  | Identify if you will cover tuition only and/or time spent completing training. |
| If upgrade to Paramedic, have you acquired a DEA license? | **Yes, No** | <https://www.deadiversion.usdoj.gov/drugreg/>  | DEA license will be required to have schedule II medications. Should be separate from MDs personal license |
| Will upgrade strictly be for interfacility and/or intercept service? | **Yes, No** |  | If you’re adding intercept or interfacility service, outline how this will be provided and if 24/7. Also insure it will not interfere with required 911 response. |

**Operational – Supplies and Equipment**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have general supplies and equipment needed for upgrade? | **Yes, No** | <https://wisconsindot.gov/Documents/safety/veh-inspect/ambulance/309.pdf>  | List starts at section 309.21, also reference the current scope of practice |
| Who will cover supply replacement? | **Service, municipality, hospital, other** |  | In general ambulance services are not allowed to bill for supplies, primarily Medicare/Medicaid |
| Is their additional capital equipment needs? | **i.e.; Cardiac monitor, ventilator, automated CPR device** |  | Consider these costs prior to implementing change. |