Ambulance Permit Renewal Check List—2023/2024

Vendor	Contact Person
STAR Ambulance	Brooke Entsminger

Item	Yes	No	Other
Completed signed renewal application form	X		
Copy of, or description of Applicant's policy or program for vehicle maintenance	X		
List or description of Applicant's radio equipment	X		
Valid California Highway Patrol inspection report for each ground ambulance	X		
Applicant's quality management practices and policies	X		
Staffing and hiring policies	X		
Organizational chart of management staff	X		
Resume of training, orientation program and experience of the Applicant in the transportation and care of patients	X		
Legible copies of current California Driver's License for each employee listed in the application.	X		
Copies of EMT Certification and/or Paramedic Licensure cards	X		
Current Fee Schedule	X		
Certificate of insurance as required by the Humboldt County Risk Manager	X		
Application fee in the amount of $196 for each service area payable to Humboldt County		X	Waved—non-profit

Specific Items for Permit Officer to Review

	Yes	No	Other
Permit Approved?			

Approved by: _____

Date: _____

County of Humboldt
Eureka, California
Ambulance Service Permit Renewal Application

Pursuant to Humboldt County Code, Title V, Division 5
Emergency Medical Services System

Applicant – DO NOT FILL OUT THIS SECTION	
Date Received:	4/21/23
Application Fee of $196.00 Received:	Yes ☐ No ☐ waived
Proof of Liability Insurance Attached:	Yes ☒ No ☐
Resumes Attached:	Yes ☒ No ☐

Applicants – Please completely fill out this section and provide all requested information/verifications:

Level of Service: ☒ **Basic Life Support** ☒ **Advanced Life Support**

☐ **Non-Emergency Transport** (check all that apply)

Ambulance Service Full Name:	**Southern Trinity Area Rescue**		
Name of Contact Person:	**Brooke Entsminger**		
Mailing Address:	**PO Box 7**	**City/Zip Code**	**Scotia 95565**
Physical Address:	**321 Mad River Rd**	**City**	**Bridgeville/ Mad River**
Telephone/ Fax Numbers	**707-574-6616 x2090**	**E-Mail**	**bentsminger@sthsclinic.org**

County of Humboldt

Eureka, California

Owner Name	Southern Trinity Health Services DBA STAR				
Address	SAME		City/Zip Code		
Phone Number	SAME	Fax Number	707-574-6523	E-Mail	SAME

County of Humboldt
Eureka, California

VEHICLES:

In conformity with the County Ordinance concerning the Permitting of Ambulance Service, the Applicant requests permission from the Permit Officer to operate the following ambulance vehicles:

	Year	Model/Make	Vehicle Identification Number	License Plate #	Length of Time In Use (Include current mileage shown on odometer)	State or Federal Aviation Agency License Number	Description of Color Scheme, Insignia Name, Monogram, ot Distinguishing Characteristics
1.	2022	Ford F350	1FDRF3HT7NDA00417	74452P3	1 YEAR (less than 5000)		Type 1 Ambulance, STAR logo in black silver , and maroon
2.	2014	Ford E350	1FDSS3EL8EDB14606	1481361	7 YEARS (42999)		Type 2 Ambulance, Southern Trinity Area Rescue written on side with Cardiac pattern.
3.							

County of Humboldt
Eureka, California

4.							
5.							
	Year	Model/Make	Vehicle Identification HTNumber	License Plate #	Length of Time In Use (Include current mileage shown on odometer)	State or Federal Aviation Agency License Number	Description of Color Scheme, Insignia Name, Monogram, ot Distinguishing Characteristics
6.							
7.							
8.							

County of Humboldt
Eureka, California

☑ Attach a copy, or provide a description, of Applicant's policy or program for maintenance of vehicles.

☑ Attach a list, or provide a description of, Applicant's radio communication equipment.

☑ Attach evidence of **currently valid California Highway Patrol inspection report** for each ground ambulance vehicle listed in the application.

☑ Applicant certifies that it has reviewed and meets the requirements set forth in Humboldt County Code, Title V, Division 5, Sections 551-5 (Standards for Ambulance Service Permit) and 551-9 (Standards for Ambulance Equipment and Operations). BE

☑ Attach copies, or provide descriptions of the following:

- Applicant's quality management practices and policy;
- Staffing and hiring policies;
- Organizational chart of management staff;
- Resume of the training, orientation program, and experience of the Applicant in the transportation and care of patients; and
- Knowledge of and/or involvement in the Humboldt County Emergency Medical Services system.

☑ Attach legible copies of current California Driver's License for each employee listed above.

☑ Provide copies of EMT certification and/or Paramedic licensure cards.

☑ Applicant certifies that the individuals listed above are qualified, duly licensed and/or certified drivers, attendants, and attendant-drivers, and said individuals are currently compliant with any and all applicable training, licensing, and permitting requirements set forth by local, state, and federal law and regulations. BE

Vehicles

Includes –
* Vehicle Maintenance Policy

COPY

Southern Trinity Health Services

Transportation Safety Policies

2008

Southern Trinity Health Services
153-A Van Duzen Road
Mad River, CA 95552

Incidents, Accidents, and Collisions

Incident Reports

Drivers shall use Incident Reports to document rider/driver accidents or any unusual occurrences (other than vehicle collisions). [Form 31: Incident Report]

These might include:

1. Interactions with doctors and nurses
2. Gatekeeper information
3. Rider complaints

Auto Collisions

Southern Trinity Health Services shall have accident kits for all drivers. A kit shall be kept in all vehicles owned by Southern Trinity Health Services and should be provided to volunteer drivers operating POV's. Drivers shall be instructed to follow the procedures contained in the accident kit.

Typically these kits include:

1. Witnesses cards
2. Measurement tool
3. Pen or pencil
4. Chalk
5. Form to diagram accident
6. Emergency numbers and procedures

Procedures and Record Keeping

1. Complete and accurate records of any collision or claim of collision, no matter how slight, must be kept in a permanent file. "Permanent" refers to "as long as is required by law." Drivers should not admit fault to anyone other than the manager or police.

2. Any claim of bodily injury or property damage must be reported to the manager immediately. Collision reports must be completed by the driver of the vehicle and reviewed by the Manager within 24 hours.

3. All collisions, no matter how slight, should be reported to the Sponsoring Organization, and a collision report submitted. However, in the event of a serious collision, the volunteer driver should contact Southern Trinity Health Services immediately. A serious collision involves severe property damage, personal injury or the potential for media involvement. [Form 32: Collision Report]

The Collision Scene

1. In the rare case that a serious or disabling collision occurs, ideally the Manager, or designated representative, should immediately go to the scene of the collision to provide support and information. It is the responsibility of the Manager to represent the program at the collision scene in a way that avoids any further liability. The Manager should bring a camera to the scene to assist with the review process.

2. Because drivers can be injured or become distraught at the scene of a collision, collision procedures and guidelines should be an important part of orientation training for new drivers.

3. It is important that the driver document who was in his/her vehicle and any vehicle that was involved in the collision. This can be done with a disposable camera which is part of the vehicle's emergency equipment.

Procedures for Managers at the Scene of a Collision

Collisions of any type can be an upsetting situation for the driver. A distraught or injured driver can increase liability for the program by what he/she says at the collision scene. For example, when a driver tells riders or bystanders, "I'm so sorry, it's my fault," the potential for claims made against the program will dramatically increase. The program should pay claim expenses it is responsible for, but it should not pay additional expenses because of erroneous statements made at the scene of the collision.

Managers should consider the following factors when called to the scene of an accident:

1. Assure that riders are accounted for and are receiving proper emergency services.

2. Separate the driver from the collision scene.

3. Speak for the program and the driver.

4. The driver should be available to answer questions from police and fire authorities.

Media Relations at the Scene of a Collision

Poor media relations at the scene of a collision can cause additional liability. Managers and program representatives should be familiar with and follow procedures when communicating with the media. Guidelines should be in place for employees or volunteers at the scene of a collision. The guidelines may include:

1. Assume the media is present.
2. Project a professional image.
3. Maintain control of the situation.
4. Do not quote hearsay or speculation.

5. Do not accept responsibility for the collision.
6. Explain "no comment" by saying, "I don't have enough information to answer that question accurately."
7. Never speak "Off the Record".
8. When interviewed on camera or video, carefully select the background. Stand in front of a neutral background, not in front of the crash.
9. Contact Southern Trinity Health Services immediately in the event of a serious collision.

Collision Review

A Review Committee, consisting of the Manager and other program representatives, is responsible for reviewing collision reports. In the event of a collision, the committee comes together to review the details of the collision and make recommendations. All collisions must be evaluated for preventability. In each case, preventability is evaluated on the basis of the following statement: "Did the driver do everything reasonably possible to avoid the circumstances that led to this collision?"

Driver Records

Southern Trinity Health Services shall have a file containing all pertinent information about each driver. The Federal Privacy Act covers volunteer drivers. All personal information about the driver should be covered by a written confidentiality policy that parallels the organization's personnel policies. The following is a list of the documents, and related information, to be maintained in driver files: [Form 33: Personnel Records Checklist]

1. Original volunteer/employment application
2. Interview and reference check documentation
3. Criminal history documentation
4. Department of Motor Vehicles (DMV) history report and any subsequent history reports generated
5. Copy of current drivers license
6. Copy of training certifications
7. On-going objective documentation
8. Any documentation relevant to performance
9. Copy of current personal automobile insurance card. Insurance must be at least the State of California's minimum coverage requirement for POV drivers. Personal auto insurance verification must be kept current.

Vehicle Records

A vehicle file shall contain sections where the following documentation is maintained:

1. Vehicle maintenance schedule
2. Maintenance records
3. Maintenance receipts
4. Description of maintenance completed
5. Daily pre-trip inspections
6. Inventory of safety equipment
7. Maintenance records for related safety equipment (i.e. fire extinguishers)

Rider Records

Southern Trinity Health Services shall maintain specific information on the riders using the services. The rider information must be collected and properly maintained using a database or an adequate system done by hand if the agency does not have access to a computer. Rider information, collected by Southern Trinity Health Services, will be used primarily for reporting purposes. In the event of an emergency, this information can also be valuable. Rider records should contain the following information:

1. Rider's name
2. Address
3. Phone number
4. Age

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Description of STAR Radio Equipment
2015

TK7360H	Kenwood 50 Watt Mobile Radio
KPS13	DC Power Supply
KMB24	Base Station Mounting Case
KMC9C	Desk Microphone
FG1523	VHF Base Station Antenna
TK2180	Kenwood Hand held portable radios

STAR owns and maintains multiple base station radios with base station antenna, at the clinic, which is our main dispatch center, as well as at each volunteer dispatcher's house. On nights and weekends STAR's dispatch is operated by volunteers out of their homes.

STAR maintains Kenwood Mobile Radios in each ambulance it operates.

STAR has multiple Kenwood hand held portable radios. 2 are kept at the clinic ambulance station, the rest are kept by each volunteer responder at their home for use while on duty or on a call.

STAR owns and maintains a repeater on the ridge behind Dinsmore to boost communication in eastern Humboldt County from Pickett Peak.

PO Box 4, 321 Van Duzen Road, Mad River, California 95552
Telephone (707) 574-6616 Fax 707-574-6523
www.sthsclinic.org

STATE OF CALIFORNIA
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

AMBULANCE INSPECTION REPORT

CHP 299 (Rev. 10-18) OPI 061

INSPECTION: [X] INITIAL [ ] ANNUAL [ ] COMPLIANCE

LEGAL BUSINESS NAME	COMPANY LICENSE NUMBER	VEHICLE YEAR, MAKE, AND MODEL
SOUTHERN TRINITY HEALTH SERVICES	1956	2022 FORD F-350
SERVICE ADDRESS (number and street)		VEHICLE IDENTIFICATION NUMBER (VIN)
321 VAN DUZEN RD		1FDRF3HT7NDA30417
(city, state, and zip code)		VEHICLE LICENSE PLATE NUMBER AND STATE
GARBERVILLE CA 95526		7445ZF3
		VEHICLE CERTIFICATE NUMBER

ITEM INSPECTED (MINIMUM REQUIREMENTS)	YES	NO	ITEM INSPECTED (MINIMUM REQUIREMENTS)	YES	NO
1. Registration; plates	✓		14. Reflectors	✓	
2. Identification certificate *(annuals/compliance only)*	✓		15. Glass	✓	
3. Ambulance identification sign (visible from 50+ feet)	✓		16. Windshield wipers	✓	
4. Headlamps	✓		17. Defroster	✓	
5. Beam selector/indicator	✓		18. Mirrors	✓	
6. Headlamp flasher *(if equipped)* N/A			19. Horn	✓	
7. Steady red warning lamp	✓		20. Siren	✓	
8. Turn signals	✓		21. Seat belts	✓	
9. Clearance/sidemarker lamps *(if required)*	✓		22. Fire extinguisher *(minimum 4B:C)*	✓	
10. Stoplamps	✓		23. Portable light	✓	
11. Taillamps	✓		24. Spare tire; jack and tools	✓	
12. License plate lamp	✓		25. Maps of coverage areas or equivalent	✓	
13. Backup lamps	✓		26. Door latches operable from inside and outside	✓	

ANY ITEM CHECKED "NO" ABOVE WILL HAVE A CHP 281, NOTICE TO CORRECT VIOLATION, ISSUED WITH THE DIRECTION TO CORRECT THE DISCREPANCY. ONCE SIGNED OFF, THE CHP 281 WILL BE RETURNED TO THE INSPECTING OFFICER.

EMERGENCY CARE EQUIPMENT AND SUPPLIES INSPECTED	YES	NO	EMERGENCY CARE EQUIPMENT AND SUPPLIES INSPECTED	YES	NO
1. (1) Ambulance cot and (1) collapsible stretcher	✓		14. Emesis basin or disposable bags, and covered waste container	✓	
2. Securement straps for patient and cot/stretcher	✓		15. Portable suctioning apparatus (Squeeze syringes not sufficient)	✓	
3. Ankle and wrist restraints. Soft ties are acceptable.	✓		16. Two devices or material to restrict movement	✓	
4. Sheets, pillow cases, blankets, towels, pillows (2)	✓		17. (2) liters saline solution or a gallon potable water	✓	
5. Oropharyngeal airways: (1) adult, (1) child, (1) infant	✓		18. Half-ring traction splint, padded ankle hitch strap, heel rest or equivalent device	✓	
6. Rigid or pneumatic splints (4)	✓				
7. Resuscitator - capable of use with oxygen or air in adult, child, and infant sizes	✓		19. Blood pressure cuff, manometer, stethoscope	✓	
			20. Sterile obstetrical supplies (gloves, umbilical cord tape or clamps, dressings, towels, syringe, and clean plastic bags)	✓	
8. Oxygen and regulators, portability required	✓				
9. Sterile bandage compresses (4 - 3" x 3")	✓		21. Bedpan or fracture pan	✓	
10. Soft rolled bandages (6 - 2", 3", 4", or 6")	✓		22. Urinal	✓	
11. Adhesive tape (2 rolls - 1", 2", or 3")	✓		23. Two spinal immobilization devices, one at least 30" in length and one at least 60" in length, with straps to adequately secure patients to the device (a combination short/long boards are acceptable)	✓	
12. Bandage shears	✓				
13. Universal dressings (2 - 10" x 30" or larger)	✓				

ARCH SPECIALTY INSURANCE COMPANY MEPK06-216517 EXP 7/31/23

DESTROY PREVIOUS EDITIONS

STATE OF CALIFORNIA
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL
AMBULANCE INSPECTION REPORT
CHP 299 (Rev. 10-18) OPI 061

REQUIRED RECORDS AND DOCUMENTS INSPECTED AND IN COMPLIANCE

CALL RECORDS	YES	NO
1. Location of records, retained for 3 years	X	
2. Date, time, location, and identity of call taker	Y	
3. Name of requesting person or agency	Y	
4. Unit ID, personnel dispatched, and record of red light/siren use	Y	
5. Explanation of failure to dispatch	Y	
6. Dispatch time, scene arrival time, and departure time	Y	
7. Destination of patient; arrival time	Y	
8. Name or other identifier of patient transported	Y	

COMPANY INSPECTION	YES	NO
9. Company principals verified	X	
10 One or more ambulances available 24 hours	Y	
11. Fees posted/current	Y	
12. Financial responsibility	Y	
13. 24-hour direct telephone service	Y	

PERSONNEL RECORDS	YES	NO
14. Employment date	X	
15. Copy of driver license	X	
16. Copy of ambulance driver certificate	Y	
17. Copy of medical exam certificate	X	
18. Copy of EMT certificate or medical license	Y	
19. Work experience summary	Y	
20. Affidavit certifying compliance with 13 CCR 1101(b) and/or Section 13372 CVC prohibitions	Y	
21. Personnel enrolled in the DMV Pull Notice System	X	

VEHICLE INSURANCE CARRIER'S NAME	POLICY NUMBER	POLICY EXPIRATION DATE
ARCH SPECIALTY INS. CO	MEP1067615-1	7/15/23

REMARKS

LICENSEE CERTIFICATION IN LIEU OF OFFICIAL BRAKE CERTIFICATE

I certify that there is no official brake adjusting station within 30 miles of the operating base of this vehicle; however, the brake system of this vehicle has been inspected and is in compliance with the requirements of the California Vehicle Code and Title 13, California Code of Regulations.

SIGNATURE OF LICENSEE OR AUTHORIZED REPRESENTATIVE	DATE
	1/6/23

☒ **TEMPORARY OPERATING AUTHORIZATION:** This vehicle may be operated as an emergency ambulance. This authorization must be carried in the vehicle when used in lieu of the special vehicle identification certificate and expires 30 days after the date shown below.

SIGNATURE OF COMMANDER OR INSPECTING OFFICER	ID NUMBER	LOCATION CODE	DATE
	19811	175	1/6/23

STATE OF CALIFORNIA
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

AMBULANCE INSPECTION REPORT

CHP 299 (Rev. 10-18) OPI 061

INSPECTION ☐ INITIAL ☒ ANNUAL ☐ COMPLIANCE

LEGAL BUSINESS NAME	COMPANY LICENSE NUMBER	VEHICLE YEAR, MAKE, AND MODEL
SOUTHERN TRINITY HEALTH SERVICES	1956	2014 FORD E350
SERVICE ADDRESS (number and street)		VEHICLE IDENTIFICATION NUMBER (VIN)
321 VAN DUZEN RD		1FDSS3EL8GDC14602
(city, state, and zip code)		VEHICLE LICENSE PLATE NUMBER AND STATE
BAYSVILLE CA 95526		1F81361
		VEHICLE CERTIFICATE NUMBER
		14202

ITEM INSPECTED (MINIMUM REQUIREMENTS)	YES	NO	ITEM INSPECTED (MINIMUM REQUIREMENTS)	YES	NO
1. Registration; plates	✓		14. Reflectors	✓	
2. Identification certificate *(annuals/compliance only)*	✓		15. Glass	✓	
3. Ambulance identification sign (visible from 50+ feet)	✓		16. Windshield wipers	✓	
4. Headlamps	✓		17. Defroster	✓	
5. Beam selector/indicator	✓		18. Mirrors	✓	
6. Headlamp flasher *(if equipped)*	✓		19. Horn	✓	
7. Steady red warning lamp	✓		20. Siren	✓	
8. Turn signals	✓		21. Seat belts	✓	
9. Clearance/sidemarker lamps *(if required)*	✓		22. Fire extinguisher *(minimum 4B:C)*	✓	
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EMERGENCY CARE EQUIPMENT AND SUPPLIES INSPECTED	YES	NO	EMERGENCY CARE EQUIPMENT AND SUPPLIES INSPECTED	YES	NO
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2. Securement straps for patient and cot/stretcher	✓		15. Portable suctioning apparatus (Squeeze syringes not sufficient)	✓	
3. Ankle and wrist restraints. Soft ties are acceptable.	✓		16. Two devices or material to restrict movement	✓	
4. Sheets, pillow cases, blankets, towels, pillows (2)	✓		17. (2) liters saline solution or a gallon potable water	✓	
5. Oropharyngeal airways: (1) adult, (1) child, (1) infant	✓		18. Half-ring traction splint, padded ankle hitch strap, heel rest or equivalent device	✓	
6. Rigid or pneumatic splints (4)	✓				
7. Resuscitator - capable of use with oxygen or air in adult, child, and infant sizes	✓		19. Blood pressure cuff, manometer, stethoscope	✓	
8. Oxygen and regulators, portability required	✓		20. Sterile obstetrical supplies (gloves, umbilical cord tape or clamps, dressings, towels, syringe, and clean plastic bags)	✓	
9. Sterile bandage compresses (4 - 3" x 3")	✓		21. Bedpan or fracture pan	✓	
10. Soft rolled bandages (6 - 2", 3", 4", or 6")	✓		22. Urinal	✓	
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12. Bandage shears	✓				
13. Universal dressings (2 - 10" x 30" or larger)	✓				

STATE OF CALIFORNIA
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

AMBULANCE INSPECTION REPORT

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3. Name of requesting person or agency	X	
4. Unit ID, personnel dispatched, and record of red light/siren use	X	
5. Explanation of failure to dispatch	X	
6. Dispatch time, scene arrival time, and departure time	X	
7. Destination of patient; arrival time	X	
8. Name or other identifier of patient transported	X	

COMPANY INSPECTION	YES	NO
9. Company principals verified	X	
10 One or more ambulances available 24 hours	X	
11. Fees posted/current	X	
12. Financial responsibility	X	
13. 24-hour direct telephone service	X	

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14. Employment date	X	
15. Copy of driver license	X	
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17. Copy of medical exam certificate	X	
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19. Work experience summary	X	
20. Affidavit certifying compliance with 13 CCR 1101(b) and/or Section 13372 CVC prohibitions	X	
21. Personnel enrolled in the DMV Pull Notice System	X	

VEHICLE INSURANCE CARRIER'S NAME	POLICY NUMBER	POLICY EXPIRATION DATE
ARCH SPECIALTY INS CO	MEAK0716317	7/15/23

REMARKS

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I certify that there is no official brake adjusting station within 30 miles of the operating base of this vehicle; however, the brake system of this vehicle has been inspected and is in compliance with the requirements of the California Vehicle Code and Title 13, California Code of Regulations.

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SIGNATURE OF COMMANDER OR INSPECTING OFFICER	ID NUMBER	LOCATION CODE	DATE
	19811	175	1/6/23

NOR-CAL EMS	3501	Emergency Medical Services System Quality Improvement Program (EMSQIP)
Nor-Cal EMS Policy & Procedure Manual		Documentation and Quality Improvement
Effective Date: 4/07/2021		Next Revision: 4/07/2024
Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR		SIGNATURE ON FILE

Authority

Health and Safety Code Division 2.5, California Code of Regulations, Title 22, Division 9. California Administrative Code, Title 22, Division 9, Chapter 1.5, 2, 3 and the Health and Safety Code, Division 2.5, Section 1797.220

Purpose

To establish Emergency Medical Services Quality Improvement Program(EMSQIP) requirements for EMS system participants.

Policy

1) AED/BLS/ALS/LALS prehospital provider organizations and base/modified base hospitals shallsubmit a written EMSQIP to Nor-Cal EMS for review and approval every five (5) years. The written EMSQIP shall include the following minimum information (template provided):

   a) Provider name and management structure, including QI coordinator, medicaldirector, and internal QI structure. Include an organizational chart if available.
   b) Description of how, how often and who collects/analyzes QI indicator data.
   c) Description of how and how often QI indicator data is shared with QI committees,technical advisory committees, peer review groups, management, etc.
   d) Description of how the provider communicates QI activities to external stakeholders (other EMS system participants, elected officials, the public, etc.).
   e) Description of the provider's approach to performance improvement and theprocess used to implement changes.
   f) Description of how provider policies and procedures are developed/revised, andhow staff are educated/trained on new/revised policies and procedures.
   g) Description of how staff are educated/trained on new/revised Nor-Cal EMS policies and protocols.
   h) Description of the process for ensuring staff complete other required EMSeducation/training.

2) All AED/BLS/ALS/LALS EMS system participants shall participate in the Nor-Cal EMS EMSQIP which may include providing records for program monitoring and evaluation.

3) AED/BLS/ALS/LALS EMS system participants shall develop a performance improvement plan when their EMSQIP identifies a need for improvement. Collaboration with Nor-Cal EMS and/or other EMS system participants will collaborate to identify system issues, will be discussed at MAC/AMAC, and a year plan will be determined.

4) All agencies with Nor-Cal EMS will be sent a year-end report form, requesting data of pre-determined criteria and narrative reviews. This data can be pulled from agency ePCRs/PCRs.

5) All provider agencies:

   a) Peer Review Audit form is available for use for EMSQIP in your agency. You may submit the forms with the yearend report for those PCRs within the criteria.
   b) The Optional Scope Utilization form shall be submitted within 7 days of the use of optional scope skills/medications.
   c) Optional Skills training rosters shall be submitted yearly to Nor-Cal EMS.

SOUTHERN TRINITY HEALTH SERVICES

Section: Operations	**Approved by: CQI and Board of Directors**
Policy: Continuous Quality Improvement Program (CQI)	**Adopted Date: 7/1/2004**
Reference Number: OPS.030	**Last CQI Review and Approval: 10/23/14** **Last BOD Review and Approval: 2/22/12**
Page 1 of 7	**Next Review and Approval: 10/28/14**

Policy

To establish and outline the structure and function of Southern Trinity Health Services (STHS) Continuous Quality Improvement Program.

Purpose/Goal

The primary mission of Southern Trinity Health Services is to improve the quality of life in Southern Trinity and Southeastern Humboldt Counties by providing access to quality, comprehensive, innovative, and integrated health care and emergency medical services regardless of ability to pay. STHS acknowledges that quality health care and the systems that support that care must be the foundation of a successful health care organization. STHS is committed to providing optimal health care for its patients consistent with regulatory and accepted standards of practice established by the STHS medical staff.

Southern Trinity Health Services recognizes that the patient experience is influenced by every aspect of the services provided and by every employee and volunteer the patient encounters. The Continuous Quality Improvement Program must be organization wide and include medical, dental, behavioral health, emergency medical services, transportation, facility, business, administrative services and the Southern Trinity Health Services Board of Directors.

Procedure

The Quality Improvement Plan assesses each area of care individually and how they interact and support patient care as a whole. The Quality Improvement process will utilize both internal and external audit systems; track and review defined clinical indicators and outcomes; sentinel events and 'near miss' incidents; patient comments, both formal and anecdotal, negative and positive; and employee reports, observations, concerns and comments.

The Continuous Quality Improvement Committee is responsible for ensuring the compliance of all policies and procedures of the organization both clinical and operational. Refer to OPS.O 19 Policy Development and Approval for further information.

Southern Trinity Health Services is committed to fostering an open and supportive environment for identifying, reporting, discussing and correcting events before they become problems. Resolution will be sought through examining systems; policy, products, tools, procedures, and education. Solutions will be rewarded; finger pointing and blame will be discouraged. Individual corrective actions, if necessary, will be conducted in private, and documented appropriately.

Continuous Quality Improvement - CQI Committee

The CQI Committee provides the leadership necessary to develop implement and oversee quality related activities. The active participation of departmental leadership is necessary to demonstrate that Southern Trinity Health Services is committed to quality and safety.

The CQI Committee is an organization-wide group composed of representatives from all departments. The following are the minimum requirements for CQI Committee composition:

Executive Director
Medical Director
Dental Director
Behavioral Health Director
Financial Officer/Administrative/ Fiscal Representative
Operations Officer – Patient flow, Front Office Representative
Provider Representatives – Medical and Dental Back Office
Risk Manager/Loss Control/ Facilities Representative
Quality Assurance Coordinator, RN
Board of Directors Representative

The Executive Director or designee serves as chair of the CQI Committee with responsibility for setting and approving agendas, leading meetings and providing leadership in the selection of CQI activities and priorities. The Executive Director may designate a CQI Coordinator with responsibility for carrying out the administrative activities necessary to conduct Committee business. The Coordinator will ensure that meetings are held at least 10-12 times per year, that minutes of meetings are taken, distributed, records and documents are maintained for HRSA reporting purposes and prepared for Board of Directors approval each month, and that scheduled activities proceed according to the established calendar.

The Committee will evaluate the effectiveness of the Continuous Quality Improvement Program annually at the February meeting per the CQI reporting calendar Cycle I.

Subcommittees of the CQI Committee

The CQI Committee will form individual or joint subcommittees to investigate significant or recurrent events, to address an ongoing need to protect confidentiality and to identify opportunities for improvement. All subcommittees shall provide a written report to the full CQI Committee. The following subcommittees are designated as permanent individual or joint committees as CQI Committee deem appropriate to meet the requirement:

The Chronic Pain Subcommittee is tasked with monitoring the Chronic Pain Program, including but not limited to overall results, outcomes, problems, appropriateness and consistency of care delivered, review of individual patient care plans referred by the providers, and all requests by providers to withdraw opiate therapy due to violations of the pain contract. Subcommittee membership is limited to Medical, Behavioral Health, and Dental providers, Executive Management, and the Risk Manager to protect confidentiality. The subcommittee shall meet monthly and shall submit a report to the full CQI Committee which full protects individual patient information.

The Chronic Disease subcommittee is tasked with reviewing data for conditions identified in the STHS Health Care Plan, the Uniform Data System report structure, and other chronic conditions identified from time to time. The subcommittee shall monitor trends, compare them to established benchmarks and goals, and recommend improvements to the CQI Committee utilizing the PDSA model. The subcommittee shall consist of the Medical, Behavioral Health. Dental providers, Executive Management, and the Risk Manager, and shall meet monthly.

Confidentiality

The review of patient data, employee performance data and other information of a sensitive nature is vital to the success of the quality improvement process. Southern Trinity Health Services requires all data to be protected. Information will only be reviewed and discussed in office spaces. All reports are confidential and will only be used for the quality improvement processes. All patient identification information shall be removed, as will all provider data for aggregate reports. Any discussion requiring patient or employee identification will be done in private.

Objectives

1. To ensure the delivery of patient care at the maximum achievable level of quality in a safe and cost effective manner.
2. To ensure the effective "hand-off "of patient care between providers and other internal and external sources of care, including support and administrative services.
3. To develop effective systems for continuous problem assessment/identification, corrective action planning, plan implementation and evaluation of organization processes and services.
4. To develop a system of accurate comprehensive data collection methods to track, trend and report quality indicators for the organization and for external reporting compliance.
5. To educate all health care professionals and staff in the philosophy procedures and practices of quality assessment.
6. To utilize information gained in quality assessment activities to direct continuing medical education at STHS.
7. To increase knowledge and participation in quality improvement activities at STHS.
8. To identify opportunities for improvement and institute continuous improvement strategies as appropriate.
9. To demonstrate the program's overall impact on improving the quality of care delivered by STHS.

QI Process

1. The Southern Trinity Health Services Health Care Plan identifies specific Health Care Goals and performance measures. The individual elements are reviewed annually by the CQI Committee on a three month rotating schedule as specified in the CQI reporting calendar Cycle I.
2. The Clinical tracking measures are developed from the Health Care Plan. The Health Care Plan defines internal goals, and establishes external benchmarking standards to be met or exceeded. The Clinical tracking measures are reviewed, progress noted, and corrective action decided upon on as scheduled in the QI reporting calendar Cycle I.

3. Quality Assurance measures including calibration of equipment, lab tracking, referral tracking, audit reports, and other regular inspection reports.

4. Quality Assurance measures are reviewed as set forth in the CQI reporting calendar Cycle 2.

5. Risk Management issues are reviewed as set forth in the CQI reporting calendar Cycle 3. Specific review items are included, but will also include any issue brought to the committee, or any issue of concern to any committee member.

6. Peer Review of assessment, treatment plans, and outcomes is a very important component of STHS CQI program. Southern Trinity Health Services is committed to fostering an open and supportive environment for identifying, reporting, discussing and correcting events before they become problems. The peer review process is intended to improve care to our patients, not to place blame. Generalized peer review results will be reviewed as indicated in the CQI reporting calendar Cycle 2. Specific concerns not able to be resolved via the peer review process will be directed to the Medical Director.

7. Identification of potential system problems or breakdowns

   a. Quality control test reports
   b. Peer review audits
   c. Patient complaints and grievances
   d. Incident reports
   e. Medical and dental record audits
   f. Clinical tracking reports
   g. Equipment Damage report forms
   h. Variance report forms
   i. Other sources may include: patient care evaluation studies, financial data, productivity reports, disease management reviews, time and motion studies, patient flow studies.
   j. Any report of an unusual nature may be considered by the CQI Committee. Anonymous or anecdotal reports will be considered generally, specific allegations will be considered on a case by case basis.

Collecting and analyzing data

STHS utilizes a tracking registry IMS/Medi-Tab in its Health Care Plan for maintaining, monitoring and improving quality of care for common chronic diseases and assuring optimal delivery of preventive services.

a. Data Collection and Information Resources
b. Reports from organization staff
c. Medical and dental records review
d. Clinical tracking indicators
e. Patient satisfaction surveys
f. Employee satisfaction surveys
g. Employee concerns and suggestions
h. Patient warnings and dismissals

The Process Improvement Model

STHS uses the PDSA (Plan, Do, Study, Act) method of process improvement to prevent adverse occurrences. If an item is entered into the CQI Committee meeting agenda, it will be followed at each meeting, and will be removed when satisfactory results have been achieved. The general flow should be similar to the following:

a. Problem/Project Identification
b. Entered into Problem/Project log by QI coordinator
c. Initial investigation/action plan developed by QI coordinator
d. Initial findings reported to QI Committee (or sub-committee) for review
e. Action plan developed and executed by QI coordinator or other individual as assigned by QI Committee
f. Results of action plan reported to QI Committee
g. If resolved, determine review period
h. If unresolved, revise and execute action plan

Incident Reporting

The purpose of reporting incidents is to identify problems or potential problems that may result in unsafe, unhealthy circumstances and outcomes in the practice. The completion of an incident/variance report demonstrates conscientiousness and concern for those involved. Communication in the form of positive feedback to providers and staff on improvements made as a result of reported incidents reinforces use of the system as a non-punitive means of identifying problems and developing solutions. Other purposes include the following:

a. To provide a record of the incident and to document factual information about the event.
b. To encourage staff to identify incidents, near misses, and hazards.
c. To provide for prompt treatment of any injuries that may have occurred.
d. To notify responsible individuals about incidents and hazards and to allow for prompt investigation of circumstances surrounding an incident.
e. To analyze information generated from reporting incidents and hazards and to take actions to prevent recurrence and improve safety.
f. To provide documentation as a part of an incident investigation, an OSHA or other required agency reports, workers compensation claim processes, disability or insurance claims.

Incident/variance reports are confidential, internal documents and are maintained in confidential risk management files. Incident/variance reports are not placed in patient medical records.

CQI Information Distribution

In order to ensure organization wide support and involvement of the entire organization, written minutes of the CQI Committee monthly meetings are submitted to the Medical Director, Executive Director for review, comment and action as appropriate. Board review and action where necessary shall be noted in the Board Meeting Minutes.

Southern Trinity Health Services also recognized that it is vital to the continued success of the Quality Improvement process that overall results, concerns, patterns and information are communicated to all employees and volunteers. This will be accomplished by discussion with all employees during the departmental team meetings. Significant findings or changes will be communicated at the monthly all staff meeting or at a special meeting if the Executive Director determines it necessary or beneficial.

Attachment A: CQI Reporting Calendar

Cycle I January, April, July, October — Healthcare Plan Review & Tracking

Clinical Tracking

a. Early entry into prenatal care
b. Childhood immunizations
c. Cervical cancer screening
d. Weight assessment and education – children
e. Weight assessment and education – adult
f. Tobacco use assessment
g. Tobacco use intervention/education
h. Asthmatic care
i. Coronary artery disease/lipid therapy
j. Ischemic Vascular Disease/antithrombotic therapy
k. Colorectal cancer screening
l. Adolescent and adult depression screening
m. Early intervention for HIV care
n. Diabetes A1c tracking
o. Hypertension
p. Birth weight
q. Oral health
r. Pain control

Cycle 2 February, May, August, November — Quality Assurance

a. Annual Evaluation of CQI Program effectiveness (February)
b. Pharmacy Report
c. X-ray QC Report
d. Lab QC Report
e. Lab Tracking
f. Referral Tracking
g. STAR Quarterly QA Report
h. Peer Review
i. Patient Satisfaction Survey – continuous

Cycle 3 March, June, September, December — Risk Management/Compliance/HR

a. Patient warnings/dismissals
b. Variance/Incident reports (medication errors, infectious disease, injuries/falls, HIPAA, etc.)
c. Loss Control/Safety reports and Forms
d. Policies & Procedures/Protocols/Standards
e. Credentialing/privileging/competency
f. Clinic licenses and certification updates – lab, x-ray etc.
g. Job Descriptions/Scope – providers and support staff
h. Employee evaluations – providers and support staff
i. Training updates - HIPAA, Infectious Disease, EMT, CPR, ACLS, OSHA, etc.
j. Employee Satisfaction Survey

Approved

Lee Lupton, Chief Executive Officer — Date 10/28/14

Michael Schafle, Medical Director — Date

Susan Gordon, President, Board of Directors — Date 10.28.14

Attachment A: CQI Reporting Calendar

Forms: QI Tracking Log
References & Controlling Documents:
PAL 2001-16
PAL 2002-22 BPHC Credentialing & Privileging
PAL 2011-05
PAL 2014-09 Notice of HRSA FTCA Health Center Policy Manual
Other STHS policies:
OPS.009 Referral policy
OPS.010 Hospital Visit tracking policy
OPS.011 Lab results tracking
OPS.012 Imaging tracking
OPS.007 Incident reporting
OPS.019 Policy Development and Approval
OPS.031 Credentialing policy
OPS.042 Pharmacy & Supply Ordering
OPS.049 Patient Satisfaction Assessment
CLN.008 Peer Review Procedure
CLN.009 Drug Room
Accreditation Association for Ambulatory Healthcare (AAAHC) accreditation documents
National Committee for Quality Assurance (NCQA)

Revisions and Reviews:
Adopted 7/11/2004
Revision 11/16/2010, 2/22/2011, 3/22/2011, 6/2112011, 10/28/2014

Southern Trinity Health Services
Southern Trinity Area Rescue

Staffing + Hiring

Serving Southern Trinity & Southeastern Humboldt Since 1979

STAR Volunteer Application Packet

Applying For: ❒ EMT ❒ Paramedic ❒ Dispatcher ❒Driver

Personal Information

Full Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact #1:

Name: _____ Relation: _____

Phone: _____

Emergency Contact #2:

Name: _____ Relation: _____

Phone: _____

Driver's License Information:

State: _____ Class: ____ Number: _____

Expiration: _____ Restrictions: _____

❒ Ambulance Endorsement ❒ Medical Expires: _____

Contact Information:

Primary Phone: (____) _____-_____ ❒ Home ❒ Mobile ❒ Work

Secondary Phone: (____) _____-_____ ❒ Home ❒ Mobile ❒ Work

Email Address: _____

Applicant Signature: _____ Date: _____

EMS Coordinator Signature: _____ Date: _____

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Certification Information: (EMT, AEMT, Paramedic, EMD Only)

❒ CPR Card Exp: _____

❒ EMT State Certification Number: _____ Exp: _____

❒ AEMT Local Accreditation Agency: ❒ NorCal ❒ North Coast

❒ Paramedic License Number: _____ Exp: _____

❒ Emergency Medical Dispatch Number: _____ Exp: _____

Required Copies

❒ Adult/Child Abuse & Domestic Violence Reporting Requirements

❒ Confidentiality/Security Agreement

❒ Copy of Driver's License (Front & Back)

❒ Copy of Ambulance Endorsement

❒ Copy of Green Driver's Medical Card (Front & Back)

❒ Copy of EMT/AEMT/Paramedic/EMD Card (Front & Back)

❒ Copy of Auto Insurance (Responders only)

❒ Pull Notice Program Authorization (Drivers Only)

❒ Copy of CPR Card

For STAR Management Use Only	
Initial Start Date:	
Radio Information:	Model: S/N:
Radio Call Sign:	
Equipment Assigned:	

Signature Date

TO BE PLACED IN EMPLOYEE'S PERSONNEL FILE
SOUTHERN TRINITY HEALTH SERVICES

Confidentiality / Security Agreement

I have received Health Insurance Portability and Accountability Act (HIPAA) training and as such, I understand that while performing my official duties I may have access to protected health information. Protected Health Information (PHI) means individually identifiable health information that is transmitted or maintained in any form or medium. Protected health information is ***NOT*** open to the public. Special precautions are necessary to protect this type of information from unauthorized access, use, modification, disclosure, or destruction.

I agree to protect the following types of information:

All data elements described as protected health information (PHI) including but not limited to:

- Addresses
- Telephone numbers
- Fax numbers
- Electronic Mail addresses
- Social security numbers
- Medical record numbers
- Birth date
- Date of death
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial number, including license plate numbers
- Device identifiers and serial numbers
- Full face photographic images and any comparable images
- Client information (such as, disability insurance claimants, recipients of public social services, participants of state/federal programs, employers, etc.)
- Information about how automated systems are accessed and operate
- Any other proprietary information.
- Any other unique identifying number characteristic, or code

I agree to protect PHI by:

All of the following means including but not limited to:

- Accessing, using, or modifying confidential, sensitive, or PHI only for the purpose of performing my official duties
- Never attempting to access information by using a user identification code or password other than my own
- Never sharing passwords with anyone or storing passwords in a location accessible to unauthorized persons.
- Never exhibiting or divulging the contents of any record or report except to fulfill a work assignment.

Issued: February 21, 2003 rev 7.26.2011

- Never showing, discussing, or disclosing confidential, sensitive information, or PHI to or with anyone who does not have the legal authority or the "need to know"
- Storing confidential, sensitive information in a place physically secure from access by unauthorized persons.
- Never removing confidential, sensitive, or PHI from the work area without authorization.
- Disposing confidential, sensitive, or PHI by utilizing an approved method of destruction, which includes shredding, burning, or certified or witnessed destruction. Never disposing such information in the wastebaskets or recycle bins.
- Reporting any violation of confidentiality, privacy or security policies

PENALTIES

Unauthorized access, use, modification, disclosure, or destruction is strictly prohibited. The penalties for unauthorized access, use, modification, disclosure, or destruction may include disciplinary action up to and including termination of employment and/or criminal or civil action.

Southern Trinity Health Services reserves the right to monitor and record all network activity including e-mail, with or without notice, and therefore users should have no expectations of privacy in the use of these resources.

DISCLAIMERS

Nothing in this document creates any express or implied contractual rights. All employees are employed on an at-will basis. Employees have the right to terminate their employment at any time, and Southern Trinity Health Services retains a similar right.

I certify that I have read, understood, and accept the Confidentiality Agreement above.

Full Name	**Department**
Signature	**Date**

Issued: February 21, 2003 rev 7.26.2011

ADULT/CHILD ABUSE & DOMESTIC VIOLENCE REPORTING REQUIREMENTS

California law requires that medical practitioners, non-medical practitioners, health practitioners and child care custodians working in health clinics and other specified public or private facilities be informed of their duty to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence.

Please read the following carefully and sign where indicated.

Section 11166 of the Penal code requires any child care custodian, medical practitioner, non-medical care practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she suspects has been the victim of a **child abuse** to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Any person who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist, as required, is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than five hundred dollars ($500) or by both. The law also provides that a person who does report as required, or who provides a child protective agency with access to a victim, shall not be civilly or criminally liable for doing so.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of a health facility who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a **dependent adult** who he or she knows has been the victim of physical abuse, or who has injuries under circumstances which are consistent with abuse, to report the known or suspected instance of physical abuse to an adult protective services agency or a local law enforcement agency immediately, or as soon as practically possible, by telephone, and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. reporting is required where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred.

Sections 11160-11163 of the California Penal Code require that any health practitioner employed in a health facility, clinic or physician's office who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a patient whom he or she knows or reasonably suspects has suffered from any wound or injury inflicted as a result of **domestic violence or spousal abuse** shall immediately, or as soon as is reasonably possible, file a telephone report to the local law enforcement agency followed by a written report within two working days.

Failure to comply with these reporting requirements may lead to a fine of up to $1,000 and/or up to six months in jail. A health practitioner who makes a report in accordance with this article shall not incur civil or criminal liability as a result of any report required or authorized by this article. Your clinical supervisor and Medical Center Administration should be notified whenever you believe that you may be required to report suspected abuse or violence.

I certify that I have read and understand this statement and will comply with my obligations under the dependent adult abuse, child abuse, and domestic violence reporting laws.

Name	Position/Department

Issued: February 21, 2003 rev 7.26.2011

STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES

A Public Service Agency

EMPLOYER PULL NOTICE PROGRAM

AUTHORIZATION FOR RELEASE OF DRIVER RECORD INFORMATION

I, _____, California Driver License Number, _____, hereby authorize the California Department of Motor Vehicles (DMV) to disclose or otherwise make available, my driving record, to my employer, _____
COMPANY NAME

I understand that my employer may enroll me in the Employer Pull Notice (EPN) program to receive a driver record report at least once every twelve (12) months or when any subsequent conviction, failure to appear, accident, driver's license suspension, revocation, or any other action is taken against my driving privilege during my employment.

I am not driving in a capacity that requires mandatory enrollment in the EPN program pursuant to California Vehicle Code (CVC) Section 1808.1(k). I understand that enrollment in the EPN program is in an effort to promote driver safety, and that my driver license report will be released to my employer to determine my eligibility as a licensed driver for my employment.

EXECUTED AT: CITY _____ COUNTY _____ STATE _____

DATE _____ SIGNATURE OF EMPLOYEE X _____

I, _____, of _____
AUTHORIZED REPRESENTATIVE COMPANY NAME

do hereby certify under penalty of perjury under the laws in the State of California, that I am an authorized representative of this company, that the information entered on this document is true and correct, to the best of my knowledge and that I am requesting driver record information on the above individual to verify the information as provided by said individual. This record is to be used by this employer in the normal course of business and as a legitimate business need to verify information relating to a driving position not mandated pursuant to CVC Section 1808.1. The information received will not be used for any unlawful purpose. I understand that if I have provided false information, I may be subject to prosecution for perjury (Penal Code Section 118) and false representation (CVC Section 1808.45). These are punishable by a fine not exceeding five thousand dollars ($5,000) or by imprisonment in the county jail not exceeding one year, or both fine and imprisonment. I understand and acknowledge that any failure to maintain confidentiality is both civilly and criminally punishable pursuant to CVC Sections 1808.45 and 1808.46.

EXECUTED AT: CITY _____ COUNTY _____ STATE _____

DATE _____ SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE X _____

To obtain a driver record on a prospective employee you may submit an INF 1119 form. To add this driver to the EPN Program you must submit the applicable forms: INF 1100, INF 1102, INF 1103, INF 1103A form. You may obtain forms at our website at www.dmv.ca.gov/otherservices, or by calling 916-657-6346.

THIS FORM MUST BE COMPLETED AND **RETAINED AT THE EMPLOYER'S PRINCIPAL PLACE OF BUSINESS *AND*** MADE AVAILABLE UPON REQUEST TO DMV STAFF.

DO ***NOT*** RETURN THIS FORM TO DMV.

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Management Staff Organization

Lee Lupton – CEO

↓

Amanda Huber- CEO

↓

Brooke Entsminger – EMS Manager

↓

Paramedics

↓

Dispatchers & EMT's

↓

Drivers

PO Box 4, 321 Van Duzen Road, Mad River, California 95552
Telephone (707) 574-6616 Fax 707-574-6523
www.sthsclinic.org

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Resume

Training:

- STAR is certified through Nor Cal EMS to instruct EMT and AEMT courses. STAR instructors put on one new course per calendar year.
- STAR has Continuing Education meetings for all local responders once a month with chart reviews included. STAR CE provider number 64-5308.
- STAR is linked with Redwood Memorial Hospital to attend Chart Review through teleconference when they are held at the hospital for North Coast EMS.
- STAR participates and organizes training opportunities with other emergency services (ex – USFS, REACH Air ambulance, Southern Trinity Volunteer Fire, Coast Guard and many more) on a regular basis.
- STAR provides dispatch training.

Orientation:

- New STAR volunteers are required to fill out the new volunteer packet (included in attached papers) and provide all documentation required on it.
- New volunteers are brought in to practice driving as well as become oriented to the ambulance before being put on the schedule.
- Volunteers who will be providing patient care are scheduled as a third person on crew until ready to provide care independently and they have been observed by current responders.

STAR has been operating as an Emergency Medical Transport 911 Ambulance service since 1979. Regular training and education of all responders is required for their certification and by STAR. Responders must remain current for the best patient care possible.

PO Box 4, 321 Van Duzen Road, Mad River, California 95552
Telephone (707) 574-6616 Fax 707-574-6523
www.sthsclinic.org

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Humboldt County EMS System

Southern Trinity Area Rescue (STAR), acknowledges that North Coast EMS oversees EMS systems within Humboldt County. STAR understands that it's operating Policies and Procedures are dictated by Nor Cal EMS, and that Nor Cal EMS has an agreement with North Coast EMS and St Joes Health System – Redwood Memorial Hospital (RMH), for STAR to operate with RMH as its base hospital and primary place to transport patients.

PO Box 4, 321 Van Duzen Road, Mad River, California 95552
Telephone (707) 574-6616 Fax 707-574-6523
www.sthsclinic.org

County of Humboldt
Eureka, California

SERVICE AREA:

In conformity with the County Ordinance concerning the Permitting of Ambulance Service, the Applicant requests permission to allow its ambulances to provide service in the following zone(s):

Zone	Northern Boundary	Eastern Boundary	Southern Boundary	Western Boundary	Indicate Zone(s) by Placing "X"
Zone 1 North	Humboldt County Line	Redwood Creek Bridge Highway 299 and School House Peak on Bald Hills Road	Indianola Cutoff (includes intersections with Hwy 101 & Old Arcata Rd and up to 1699 block of Peninsula Drive (in Manila)	Pacific Ocean	
Zone 2 East	Humboldt County Line	Humboldt County Line	Redwood Creek Bridge Hwy 299	School House Peak on Bald Hills Road	x
Zone 3 Central	Indianola Cutoff (includes intersections with Hwy 101 & Old Arcata Rd and up to 1700 block of Peninsula Drive (in Manila)	Showers Pass	Hookton Road & Hwy 101	Pacific Ocean	

County of Humboldt
Eureka, California

Zone	Northern Boundary	Eastern Boundary	Southern Boundary	Western Boundary	Indicate Zone(s) by Placing "X
Zone 4 South – Fortuna Sub-Zone	Hookton Road & Hwy 101	Showers Pass Humboldt County Line	Dyerville Bridge & Hwy 101 & Alderpoint Blocksburg Road 7 miles South of SR 36	Pacific Ocean	x
Zone 4 South – Garberville Sub-Zone	Dyerville Bridge & Hwy 101 & Alderpoint Blocksburg Road 7 miles South of SR 36	Humboldt County Line	Mattole/ Ettersburg Road at Ettersburg Bridge Humboldt County Line	Pacific Ocean	x

AMBULANCE SERVICE RATES:

In conformity with the County Ordinance concerning the Permitting of Ambulance Service, the Applicant must submit a completed Rates & Schedule of charges. Upon the approval by the Board of Supervisors, these rates must remain effective and may not be amended except with the consent of, or by the order of the Board of Supervisors.

☑ Rates & Schedule attached

AMBULANCE SERVICES PROVIDED

Patient Name: Proposed Feb **Date:**

Unit Dispatched 304 ☐
305 ☐

Responder #_____ Name_____

Responder #_____ Name_____

Responder #_____ Name_____

TIMES

Dispatched _____
ENROUTE _____
On Scene _____
LEFT SCENE _____
At Destination _____
AVAILABLE _____
Cancelled _____
Back at Base _____

MILES

Beginning _____
On Scene _____
response miles (_____)
At Destination _____
patient miles (_____)
Back at Base

ADVANCED LIFE SUPPORT

ALS	Code	Fee	
ALS Emergency Transport	A0370	$ 484.17	
ALS Response Miles	A0390.1	$ 17.50	
ALS Patient Miles	A0390.0	$ 17.50	
ALS Dispos Supplies/Defib	A0392	$ 35.00	
ALS Protective Disposables	A0398.2	$ 2.00	
Multiple Patient #_____	A0370.5	$ 484.17	
ALS Restraints	A0398.7	$ 40.00	

BASIC LIFE SUPPORT

BLS	Code	Fee	
BLS Emergency Transport	A0362	$ 407.72	
BLS Response Miles	A0380.1	$ 17.50	
BLS Patient Miles	A0380.0	$ 17.50	
BLS Dispos Supplies/Defib	A0392	$ 35.00	
BLS Protective Disposables	A0382.2	$ 2.00	
Multiple Patient #_____	A0362.1	$ 407.72	
BLS Restraints	A0282.7	$ 40.00	

ALS/BLS SERVICES/PROCEDURES

Procedures	Code	Fee	
Extricate / Rough Terrain	A0370.4	$ 100.00	
Extra Ambulance Attendant	A0424	$ 20.00	
Night Fee 7 pm to 7 am	A0370.1	$ 50.00	
Wait Time _____hrs	A0420	60.00/hr	
Spinal Immobilization	A0390.4	$ 60.00	
Oxygen/Oxygen Supplies	A0422	$ 100.00	
Intubation	A0396.2	$ 75.00	
Suction	AK0192	$ 50.00	
Drug Administration	A0394.5	$ 40.00	
IV Administration & Supplies	A0394	$ 98.00	
Irrigation		$ 10.00	
MAST		$ 50.00	
Delivery	A59410	$ 50.00	
Defibrillation	A0392.2	$ 95.00	
CG/EKG Monitor	A0370.3	$ 85.00	
Blood Draw	A0370.2	$ 20.00	
Glucose Determination	A0382.8	$ 15.00	
PR	A0384	$ 50.00	
Assesment- On Scene	A0998	$484.17	

DISPOSABLE SUPPLIES

Description	Code	Fee	
Trauma Dressing	A0382.9	$ 10.00	
Linens Not Replaced	A0999.1	$ 10.00	
Head Immobil. Cover Bag	A0382.3	$ 15.00	
Splint - Simple Limb	A4570	$ 15.00	
Splints, Vacuum	A0398.8	$ 75.00	
Splints, Traction	A0370.6	$ 50.00	
Hot Pack	A0382.4	$ 19.50	
Cold Packs	A0382.5	$ 19.50	
OB Kit	A0382.6	$ 22.00	
Burn Kit	A0384.1	$ 75.00	
Breathing Treatment	A0999	$ 15.00	
Fluids, NS 1000 cc	A8394.5	$ 12.00	
Fluids, NS 500 cc	A0394.3	$ 8.00	

MED/OTHER

Complaint

Complaint	Code	
PAIN		
PAIN Abdominal NOS	789.00	
PAIN Abdominal RUQ	789.01	
PAIN Abdominal RLQ	789.03	
PAIN Abdominal LUQ	789.02	
PAIN Abdominal LLQ	789.04	
PAIN Chest Wall/Respiration	786.52	
PAIN Shoulder	719.41	
PAIN Hand	719.44	
PAIN Foot	719.47	
PAIN Back	724.5	
PAIN Limb	729.5	
PAIN Knee	719.46	
PAIN Joint (multiple sites)	719.49	
PAIN Facial/Headache	784.0	
Muscle Spasm	728.85	
Numbness/Tingling	782.0	
Dislocated Knee	836.50	
Ankle Sprain/Strain	845.00	
Open Wound - Scalp	873.0	
Open Wound - Finger	883.0	
Open Wound-knee,ankle,leg	891.0	
Facial Lacerations	873.40	
Amputated Finger (s)	886.0	
FRACTURES (open)		
Arm R L _____		
Leg R L _____		
Rib		
Other:		
FRACTURES (closed)		
Arm R L _____		
Leg R L _____		
Rib		
Other:		
CIRC. / RESP. / MENTAL		
Cardiac Arrest	427.5	
Dysrhythmia	427.89	
CVA/Stroke	436	
Hypotension	458.9	
Tachycardia/Rapid Beat	785.0	
Dyspnea (SOB)	786.0	
Asthma Attack	493.92	
Respiratory Disease	519.9	
Hemorrhage, Rectal	569.3	
Nose Bleed	784.7	
Altered Level Conscious	780.0	
Loss of Consciousness	780.09	
Bi-Polar - Depression	296.5	
Suicidal	300.9	
Diabetic Complication	250.9	
Un Responsive	255.4	
Seizure/Convulsions	780.39	
Vertigo/Dizziness	780.4	

Complaint continued

Complaint	Code	
CIRC. / RESP. / MENTAL CONT.		
Labor	644.0	
Dehydration	276.5	
Nausea & Vomit	787.01	
Alcohol Abuse - Continuous	305.01	
Alcohol Abuse - unspecified	305.0	
Liver Failure (Chronic)	572.8	
Vomitting Blood	578.0	
Disorder, Penis	607.9	
Trauma	959.9	
Traumatic Shock	958.4	
Allergy Unspec.	995.3	
Sting-toxic venom (BEE etc)	989.5	
Poisoning by Psych. Drug	969.4	
Tick Bite	919.4	
Foreign Body in Mouth	935.0	
Death (within last 24 hrs)	798.2	

EXTERNAL CAUSES

Cause	Code	
Circle Type of Vehicle & Driver or Passngr		
Car/Truck Driver .0	Passngr .1	
Motorcycle Driver .2	Passngr .3	
Recreational (Quad etc.)	Other	
Boat Powered .1	Unpowered .0	
Traffic E810-E819		
Hwy Collision w/vehicle	E811	
Hwy Collision w/Pedestrian	E814	
Hwy Collisionw/Obj./Animal	E815	
Hwy No Collis.Lose Control	E816	
Boarding/Alighting Vehicle	E817	
Non Traffic E820-E825		
Off Hwy Overturn/Fall Off	E821	
Off Hwy Collis w/obj/animal	E822	
Off Hwy Collis w/fixed obj.	E823	
Fall/Slip E880-E886		
Fall out bldg/structure	E882	
Fall one level to another	E884.9	
Fall on/from stairs or steps	E880.9	
Fall on same level slip/trip	E885.9	
Fall same level collis. w/pers	E886	
Fall result in striking object	E888.1	
Assault E960-E969		
Unarmed Fight/Brawl	E960.0	
Assault w/Blunt Object	E968.2	
Assault w/Rifle	E965.2	
Assault w/Shotgun	E965.1	
Rape/Sexual Assault	E960.1	
Legal Intervention (Police)	E970 - E978	

OTHER

County of Humboldt
Eureka, California

INSURANCE:

Current proof-of-insurance certificates, indicating compliance with the requirement listed below, must be included with this application:

A. CONTRACT SHALL NOT BE EXECUTED BY COUNTY and the CONTRACTOR is not entitled to any rights, unless certificates of insurances, or other sufficient proof that the following provisions have been complied with, and such certificate(s) are filed with the Clerk of the Humboldt County Board of Supervisors.

B. CONTRACTOR shall and shall require any of its subcontractors to take out and maintain, throughout the period of this Agreement and any extended term thereof, the following policies of insurance placed with the insurers authorized to do business in California and with a current A.M. Best rating of no less than A:VII or its equivalent against injury/death to persons or damage to property which may arise from or in connection with the activities hereunder of CONTRACTOR, its agents, officers, directors, employees, licensees, invitees, assignees or subcontractors:

1. Comprehensive or Commercial General Liability Insurance at least as broad as Insurance Services Office Commercial General Liability coverage (occurrence form CG 0001), in an amount of Two Million Dollars ($2,000,000) per occurrence for any one (1) incident, including, personal injury, death and property damage. If a general aggregate limit is used, either the general aggregate limit shall apply separately to this project or the general aggregate shall be twice the required occurrence limit.

2. Automobile/Motor liability insurance with a limit of liability of not less than One Million Dollars ($1,000,000) combined single limit coverage. Such insurance shall include coverage of all "owned", "hired", and "non-owned" vehicles or coverage for "any auto."

3. Workers Compensation as required by the Labor Code of the State of California, with Statutory Limits, and Employers Liability Insurance with limit of no less than One Million Dollars ($1,000,000) per accident for bodily injury or disease. Said policy shall contain or be endorsed to contain a waiver of subrogation against

COUNTY, its officers, officials, agents, representatives, volunteers, and employees. In all cases the above insurance shall include Employers Liability coverage with limits of not less than One Million Dollars ($1,000,000) per accident for bodily injury and disease.

4. Insurance Notices must be sent to:

   County of Humboldt
   Attention: Risk Management
   825 5th Street, Room 131
   Eureka, CA 95501

5. The Comprehensive General Liability shall provide that the COUNTY, its officers, officials, employees, representatives, agents, and volunteers, are covered as additional insured for liability arising out of the operations performed by or on behalf of CONSULTANT. The coverage shall contain no special limitations on the scope of protection afforded to the County, its officers, officials, employees, and volunteers. Said policy shall also contain a provision stating that such coverage:
   a. Includes contractual liability.
   b. Does not contain exclusions as to loss or damage to property caused by explosion or resulting from collapse of buildings or structures or property underground commonly referred to "XCU Hazards".
   c. Is primary insurance as regards to County of Humboldt.
   d. Does not contain a pro-rata, excess only, and/or escape clause.
   e. Contains a cross liability, severability of interest or separation of insureds clause.

☑ Attach Certificate of Liability Insurance naming County of Humboldt certificate holder.

ADDITONAL INFORMATION:

Please provide, in writing and attach, a description of the facts relied on by the Applicant in asserting that the public health, safety, welfare, convenience and necessity warrant the granting of the ambulance service permit.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 7/17/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Pauli-Shaw Insurance Agency 627 7th St Arcata CA 95521	**CONTACT NAME:** Laura Knight **PHONE (A/C, No, Ext):** 707-822-7251 **FAX (A/C, No):** 707-826-9021 **E-MAIL ADDRESS:** laura@pauli-shaw.com
INSURED SOUTTRI-01 Southern Trinity Area Rescue PO Box 7 Scotia CA 95565	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** State Compensation Insurance Fund of California / 35076 **INSURER B :** Arch Specialty Insurance Company / 21199 **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** 1805261904 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	Y		MEPK06766318	7/15/2023	7/15/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 10,000,000 $ 10,000,000
B	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY			MEPK06766318	7/15/2023	7/15/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED X RETENTION $ 0			MEUM06795518	7/15/2023	7/15/2024	EACH OCCURRENCE AGGREGATE	$ 2,000,000 $ 4,000,000
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	Y	9093342-23	4/1/2023	4/1/2024	PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
B	Emergency Svcs E&O Medical Malpractice Liab			MEPK06766318	7/15/2023	7/15/2024	Limit Limit	Included Included

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Re: Ambulance Service Permit Requirements
When required by written contract or agreement the following may apply:
Additional Insured
Primary Wording
Waiver of Subrogation
When available, form(s) may be attached.

CERTIFICATE HOLDER

County of Humboldt, it's officers, officials, employees, representatives, agents and volunteers
Attn: Risk Management
825 5th Street, Room 131
Eureka CA 95501

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ENDORSEMENT AGREEMENT
WAIVER OF SUBROGATION

REP 14
9093342-23
RENEWAL
NA
0-76-74-93
PAGE 1

STATE COMPENSATION INSURANCE FUND

HOME OFFICE
SAN FRANCISCO

ALL EFFECTIVE DATES ARE AT 12:01 AM PACIFIC STANDARD TIME OR THE TIME INDICATED AT PACIFIC STANDARD TIME

EFFECTIVE APRIL 28, 2023 AT 12.01 A.M.
AND EXPIRING APRIL 1, 2024 AT 12.01 A.M.

SOUTHERN TRINITY HEALTH SERVICES

PO BOX 7
SCOTIA, CA 95565

ANYTHING IN THIS POLICY TO THE CONTRARY NOTWITHSTANDING, IT IS AGREED THAT THE STATE COMPENSATION INSURANCE FUND WAIVES ANY RIGHT OF SUBROGATION AGAINST,

COUNTY OF HUMBOLDT

WHICH MIGHT ARISE BY REASON OF ANY PAYMENT UNDER THIS POLICY IN CONNECTION WITH WORK PERFORMED BY,

SOUTHERN TRINITY HEALTH SERVICES

IT IS FURTHER AGREED THAT THE INSURED SHALL MAINTAIN PAYROLL RECORDS ACCURATELY SEGREGATING THE REMUNERATION OF EMPLOYEES WHILE ENGAGED IN WORK FOR THE ABOVE EMPLOYER.

IT IS FURTHER AGREED THAT PREMIUM ON THE EARNINGS OF SUCH EMPLOYEES SHALL BE INCREASED BY 03%.

NOTHING IN THIS ENDORSEMENT SHALL BE HELD TO VARY, ALTER, WAIVE OR EXTEND ANY OF THE TERMS, CONDITIONS, AGREEMENTS, OR LIMITATIONS OF THIS POLICY OTHER THAN AS ABOVE STATED. NOTHING ELSEWHERE IN THIS POLICY SHALL BE HELD TO VARY, ALTER, WAIVE OR LIMIT THE TERMS, CONDITIONS, AGREEMENTS OR LIMITATIONS IN THIS ENDORSEMENT.

COUNTERSIGNED AND ISSUED AT SAN FRANCISCO: MAY 1, 2023

2570

AUTHORIZED REPRESENTATIVE

PRESIDENT AND CEO

Additional Information

APPROVAL TO PROVIDE ADVANCED LIFE SUPPORT TRANSPORT

SOUTHERN TRINITY AREA RESCUE (STAR)

EMT/AEMT/PARAMEDIC

THIS AGREEMENT is entered into by and between SOUTHERN TRINITY AREA RESCUE (STAR), hereinafter referred to as PROVIDER, and NORTHERN CALIFORNIA EMS, INC., a California non-profit corporation, hereinafter referred to as NOR-CAL EMS.

WHEREAS, NOR-CAL EMS is a regional multi-county Local Emergency Medical Services Agency in northern California including Trinity County, and

WHEREAS, PROVIDER desires to be approved by NOR-CAL EMS to provide Advanced Life Support (ALS) and Basic Life Support (BLS) transport services in certain parts of Trinity County, and

WHEREAS, NOR-CAL EMS, contingent upon PROVIDER complying with the conditions set forth below, approves PROVIDER as an ALS and BLS Transport provider,

NOW, THEREFORE, it is agreed by and between the parties hereto as follows:

When signed by both parties this document serves as the approval and designation by NOR-CAL EMS of PROVIDER as a service provider, to provide emergency medical response per provider availability. PROVIDER agrees to have complied with all requirements of this agreement and with all of NOR-CAL EMS' policies and procedures related thereto.

PROVIDER'S primary response area is STAR boundaries, Trinity County.

PROVIDER'S Trinity County office is located at Mad River, California.

This approval is developed in compliance with the current California Health and Safety Code, California Code of Regulations, Title 22, Division 9, Chapters 2, 3 and 4 and NOR-CAL EMS Policies and Procedures. PROVIDER agrees to comply with all California laws applicable to providers of prehospital emergency medical services.

1. PROVIDER REQUIREMENTS

As an approved service, PROVIDER agrees to comply with all policies and procedures contained in NOR-CAL EMS' Policies and Procedures Manual. By signing this Agreement, PROVIDER affirms that PROVIDER has read and understands the policies and procedures relating to PROVIDER's type of service. PROVIDER further agrees to keep up to date on changes in those policies and procedures and to implement those that require implementation. In addition PROVIDER further agrees to the following:

A. EMERGENCY MEDICAL TECHNICIAN OPTIONAL SCOPE OF PRACTICE

PROVIDER is approved for the following Optional Scope of Practice:

1. Perilaryngeal Airway: Provider will transition from the Combi-tube to the King Airway by July 1, 2014.
2. Automated External Defibrillation

B. QUALITY IMPROVEMENT

1. PROVIDER will allow inspection, at any time, by NOR-CAL EMS, with or without notice, for the purpose of verifying the Provider Agreement, Regulations, and Policies and Procedures compliance.
2. PROVIDER will participate in the NOR-CAL EMS Continuous Quality Improvement (CQI) program.
3. PROVIDER will designate an employee to act as the CQI program manager to oversee and assist in development and ongoing performance of PROVIDER's CQI program.
4. PROVIDER will establish a CQI program, which will identify methods of improving the quality of care provided. PROVIDER may create its own CQI program, or use the NOR-CAL EMS CQI program. PROVIDER will furnish NOR-CAL EMS with a copy of its CQI program for approval, and provide any changes, as they occur.
5. PROVIDER will submit to NOR-CAL EMS, on a quarterly basis, a CQI data analysis summary.

C. REPORTS/RECORDS

1. PROVIDER will supply NOR-CAL EMS with a roster of all prehospital personnel upon request.
2. PROVIDER is to use an electronic Patient Care Record (PCR) system that is compatible with reporting requirement of the California State Emergency Medical Services Authority and make those records available to NOR-CAL EMS.
3. PROVIDER will comply with any requests from NOR-CAL EMS for records or pertinent materials that may be required in the course of investigations, or inquiries.

4. All records maintained pursuant to this policy will be available for inspection, audit, or examination by NOR-CAL EMS, or by their designated representatives, and will be preserved by PROVIDER for at least three (3) years from the termination of the agreement. PROVIDER's records will not be made available to parties or persons outside NOR-CAL EMS without the PROVIDER's prior written consent; unless a subpoena or other legal order compels disclosure.
5. Upon written request of NOR-CAL EMS, PROVIDER will prepare and submit written reports on any incident arising out of services provided under the agreement. NOR-CAL EMS recognizes that any report generated pursuant to this paragraph is confidential in nature and will not be released, duplicated, or made public without the written permission of the PROVIDER or unless a subpoena or other legal order compels disclosure.
6. PROVIDER will ensure that hand-written PCRs are completed by the PROVIDER's personnel, and left at the receiving facility for each patient transported, prior to personnel leaving the facility, for any response, other than another prehospital call. The electronic PCR shall be completed upon return to the PROVIDER's home location or as quickly as feasible.
7. PROVIDER will provide additional information, and reports as NOR-CAL EMS may require, from time to time, to monitor PROVIDER's performance under this agreement.
8. PROVIDER will ensure that written documentation is provided to the receiving facility staff to provide continuity of patient care personnel per NOR-CAL EMS Policies.

D. STANDARDS

In each instance of an ALS ambulance failure on a medical emergency call, resulting in the inability to continue the response, PROVIDER will submit an Unusual Occurrence Report to NOR-CAL EMS, which will include:

1. How long it took for another ambulance to respond to the same call.
2. Which ambulance service provider responded, and the level of care provided.
3. The reason or suspected reason(s) for vehicle failure, and/or, malfunction.
4. Actions PROVIDER has taken to prevent similar failures.

E. TRAINING

PROVIDER will designate a training officer to oversee the required training and orientation of all new prehospital personnel employed by PROVIDER. Qualifications for training officers for optional scope and required training procedures are outlined in NOR-CAL EMS Policies and Procedures. PROVIDER will ensure that all employees providing patient care comply with training requirements as established by the State of California and NOR-CAL EMS for their level of certification.

F. LEVEL OF SERVICE

All requirements relating to the level of service authorized contained in the Emergency Medical Service System and the Prehospital Medical Care Personnel Act (California Health and Safety Code) and the regulation derived therefrom are hereby incorporated in this agreement as if fully set forth herein.

G. COMPLIANCE WITH LAWS AND POLICIES

PROVIDER will adhere to all federal, state, county and city statutes, ordinances, and NOR-CAL EMS Policies and Procedures related to operations, including qualification of crews and maintenance of equipment.

2. INDEMNITY

PROVIDER and NOR-CAL EMS shall hold each other harmless and indemnify each other against all claims, suits, actions, costs, counsel fees, expenses, damages, judgments, or decrees, arising out of PROVIDER's performance or failure to perform under this agreement including, but not limited to, bodily injury, including death, or property damage caused by PROVIDER, or any person employed by PROVIDER, or in any capacity during the progress of the work, whether by negligence or otherwise.

3. SUSPENSION AND REVOCATION

NOR-CAL EMS may deny, suspend or revoke the approval of PROVIDER for failure to comply with the provisions of this agreement or NOR-CAL EMS Policies and procedures.

4. TERM

This agreement shall, subject to the limitations contained herein, be for an initial term of twenty-four (24) months beginning February 1, 2014, and shall be automatically renewed for successive twenty-four (24) month periods; provided, however, prior to the renewal, NOR-CAL EMS will issue a letter of renewal or nonrenewal. In the event NOR-CAL EMS issues a nonrenewal letter, that letter shall also serve as a sixty (60) day notice of termination of this Provider Agreement. Any notice required by this approval will be in writing and any notice to NOR-CAL EMS will be to the Chief Executive Officer.

5. TERMINATION

This agreement may be terminated by either party, without cause, by giving sixty (60) days written notice to the other party.

6. NOTICE

Notices required by this approval will be in writing and be addressed in the following form:

NORTHERN CALIFORNIA EMS, INC.
Chief Executive Officer
1890 Park Marina Dr., Suite 200
Redding, CA 96001

SOUTHERN TRINITY AREA RESCUE (STAR)
Administrator
P.O. 4
Mad River, CA 95552

All terms and conditions of this approval are agreed to be binding on NOR-CAL EMS and PROVIDER.

NORTHERN CALIFORNIA EMS, INC.

Signature: _____ Date: 1/13/14
Dan Spiess, Chief Executive Officer

SOUTHERN TRINITY AREA RESCUE (STAR)

Signature: _____ Date: 2/4/14
Print Name: RAMON Pena
Title: CEO

AGREEMENT TO ACT AS BASE HOSPITAL

PROVIDER is assigned to **REDWOOD MEMORIAL HOSPITAL, FORTUNA, CA** as its Base Hospital, providing medical control as described in the California Health and Safety Code. By signing this agreement the authorized representative of **REDWOOD MEMORIAL HOSPITAL** agrees that **REDWOOD MEMORIAL HOSPITAL** will be the base hospital for **PROVIDER** subject to all the terms and conditions contained in the Base Hospital agreement between **NOR-CAL EMS** and **BASE HOSPITAL**.

Base Hospital acknowledges receipt of a fully executed copy of this agreement.

BASE HOSPITAL: REDWOOD MEMORIAL HOSPITAL, FORTUNA

Signature: _____ Date: 1/31/14
Print Name: DAVID O'BRIEN
Title: PRESIDENT

County of Humboldt
Eureka, California

(Information may include the ability of the Applicant to provide ambulance service within established response times for the type of vehicle operated, twenty-four (24) hours per day, seven (7) days per week, year-round; per-approval by North Coast EMS as an Advanced Life Support Provider; familiarity with Humboldt County; prior or additional relevant experience, etc.).

☑ Additional Information statement attached

Nor Cal EMS Contract

I, hereby attest that, STAR, (name of ambulance company) has obtained all licenses required by law and is in compliance with standards for providing emergency and/or non-emergency medical services as outlined in the Humboldt County Code, Title V, Division 5, Emergency Medical System, the policies established by North Coast EMS, and all other applicable state and federal law and regulations. All information provided herein is true and complete as of the date listed below.	
Signature of Applicant:	
Printed Name and Title	Brooke Entsminger EMS Manager
Date:	4/22/23

Required Paperwork Checklist

☑ Application complete

☑ Certificate of Automobile and liability coverage

County of Humboldt
Eureka, California

☑ Verification that each vehicle listed in application has been certified by the California Highway Patrol and/or the Health Officer pursuant to County Ordinance Section 551-9

☑ Certificate of Workers Compensation Insurance compensation coverage

☑ Proposed Rates & Schedule of Charges

☑ All requested documentation of Applicant's policies and programs (as set forth in the application) are attached and complete

☒ Application fee or proof of payment of application fee

waived – non profit