# INDIAN RIVER COUNTY
# DEPARTMENT OF EMERGENCY SERVICES

## APPLICATION FOR
## CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY (COPCN)

APPLICANT NAME: We Care of the Treasure Coast, Inc. DATE: 10/3/2019

**APPLICATION FEE: $100.00 APPLIES TO INITIAL APPLICATIONS ONLY.**
If payment applicable, make check payable to INDIAN RIVER COUNTY FIRE RESCUE.

☐ This is a new application; fee is attached.
☑ This is a renewal of our present COPCN.
☐ This is a renewal of our present COCPN with ownership or classification changes.

I. CLASSIFICATION OF CERTIFICATE REQUESTED
Please check applicable boxes and options.

**Class A** ☐ ☐ **BLS** ☐ **ALS**
Governmental entities that use advanced life support vehicles to conduct a pre-hospital EMS ALS/BLS service.

**Class B** ☑ ☑ **BLS** ☑ **ALS**
Agencies that provide non-emergency ambulance inter-facility medical transport at the ALS/BLS level.

**Class C** ☐ ☐ **BLS** ☐ **ALS**
Agencies that provide non-emergency ambulance inter-facility medical transports which require special clinical capabilities and require a physician's order.

**Class D** ☐ ☐ **BLS** ☐ **ALS**
Agencies that provide non-emergency ambulance medical transports limited to out of county transfers.

**Class E** ☐ ☐ **Wheelchair** ☐ **Wheelchair/Stretcher** ☐ **Ambulatory Transport**
Agencies that provide wheelchair transportation service only where said services *are paid* for in part or in whole either directly or indirectly with government funds.

**Class E1** ☑ ☐ **Wheelchair** ☐ **Wheelchair/Stretcher** ☐ **Ambulatory Transport**
Agencies that provide wheelchair vehicle service where said services *are not paid* for in part or in whole either directly or indirectly with government funds.

## II. COMPANY DETAILS

1. NAME OF AMBULANCE SERVICE: We Care of the Treasure Coast, Inc.

   MAILING ADDRESS: 1971 SW Biltmore Street

   CITY Port St. Lucie COUNTY St. Lucie

   ZIP CODE: 34984 BUSINESS PHONE: 772-398-0845

2. TYPE OF OWNERSHIP(i.e. Private, Government, Volunteer, Partnership, etc.):

   Private

3. MANAGER'S NAME: Havalambos Barakos

   ADDRESS: 1971 SW Biltmore St. PSL FL 34984

   PHONE #: 772-398-0845

4. PROVIDE NAME OF OWNER(s) OR LIST ALL OFFICERS, PARTNERS, DIRECTORS, AND SHAREHOLDERS, IF A CORPORATION (attach a separate sheet if necessary):

| NAME | ADDRESS | POSITION |
|---|---|---|
| Haralambos Barakos | 1971 SW Biltmore St. PSL | President |
| | | |
| | | |

5. PROVIDE NAMES AND ADDRESSES OF AT LEAST THREE (3) LOCAL REFERENCES

| NAME | ADDRESS | PHONE # |
|---|---|---|
| Encompass Health | 1600 37th St. Vero Beach | 772-778-2100 |
| Hospices of Martin | 1201 SE Indian St. Stuart Fl | 772-403-4500 |
| Access 2 Care | 1631 Bay Vista Dr | 772-450-3210 |

6. FUNDING SOURCE: Private

7. RATE SCHEDULE ATTACHED? YES ☐ NO ☑ N/A ☐

8. LIST THE ADDRESS(es) OF YOUR BASE AND ALL SUB-STATIONS:

1971 SW Biltmore St. Port St. Lucie FL 34984

## III. COMMUNICATIONS INFORMATION:

TYPES OF RADIOS/EQUIPMENT:

Motorola HT 1250 Mobile/Cell Phone

1. RADIO FREQUENCY (ies)

2. RADIO CALL NUMBER(s)

3. LIST ALL HOSPITALS AND OTHER EMERGENCY AGENCIES WITH WHICH YOU HAVE DIRECT RADIO COMMUNICATIONS:

| FROM AMBULANCE | FROM BASE STATION |
|---|---|
| All hospitals within Indian River County | All hospitals within State of Florida |

## IV. ADDITIONAL INFORMATION REQUIRED TO BE SUBMITTED WITH THIS APPLICATION:

1. Factual Statement indicating the public need and services, including studies supporting the demonstrated demand and feasibility for the proposed service(s) and deficiencies in existing services, and any other pertinent data you wish to be considered.

2. Factual statement of the proposed services to be provided, including type of service, hours and days of operation, market to be served, geographic areas to be serviced, and any other pertinent data you wish to be considered.

3. Factual Statement indicating the ability of the applicant to manage and provide the proposed services, including the management plan, maintenance facilities, insurance program, accounting system, system for handling complaints, system for handling accidents and injuries, system for providing the county monthly operating reports and any other pertinent data you wish to be considered.

4. Copy of Standard Operating Procedures.

5. Copy of Medical Protocols.

6. Copy of your insurance policy – must show coverage limits –

7. Vehicle Information. For each vehicle provide the following:
    a. Make, Model, Year, Manufacturer
    b. Mileage
    c. VIN #
    d. Tag Number
    e. Passenger capacity (E/E1 classification)
    f. Indicate ALS/BLS (A-D classification)

8. Personnel Roster. For each employee provide the following:
    a. Name – Last, First and Middle Initial
    b. Driver's License # (if commercial, specify class) & Expiration Date
        ADDITIONAL INFO REQUIRED FOR A-D classifications
    c. Emergency Medical Service Certification and # (EMT or Paramedic)
    d. Expiration date of Certification
    e. Whether or not has an Emergency Vehicle Operation Certificate.

9. Fee Schedule Including:
    Service Type, Base Rate, Mileage, Waiting and Special Charges

v. **NOTARIZED STATEMENTS Fill in Statements as applicable.**

**E or E1 APPLICANTS**

**I,** Haralambos Barakos **, the representative of**

**Applicant Name**

We Care of the Treasure Coast, Inc. **, do hereby attest that the**

**Business Name of Service**

**above named service meets all the requirements of, and that I agree to comply with, all applicable provisions of Chapter 304, Life Support and Wheelchair Services.**

**A-D APPLICANTS**

**I, _____, the representative of**

**Applicant Name**

**_____, do hereby attest that**

**Business Name of Service**

**the above named service will provide continuous service on a 24-hour, 7-day week basis. I do hereby attest that the above named service meets all the requirements for operation of an ambulance service in the State of Florida as provided in Chapter 401, Part III, Florida Statutes, Chapter 64E-2, Florida Administrative Code, and that I agree to comply with all the provisions of Chapter 304, Life Support Services.**

**ALL APPLICANTS**

**I further acknowledge that discrepancies discovered during the effective period of the Certificate of Public Convenience and Necessity will subject this service and its authorized representatives to corrective action and penalty provided in the referenced authority and that to the best of my knowledge, all statements on this application are true and correct.**

_____

**APPLICANT SIGNATURE DATE**

Before me personally appeared the said_____ who says that he/she executed the above instrument of his/her own free will and accord, with full knowledge of the purpose thereof. Sworn and subscribed in my presence this _____ day of _____, 201__.

_____ My commission expires: _____

NOTARY PUBLIC