INDIAN RIVER COUNTY
DEPARTMENT OF EMERGENCY SERVICES

APPLICATION FOR
CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY (COPCN)

APPLICANT NAME: Coastal Health Systems of Brevard, Inc. DATE: 3/21/2022

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: Coastal Health Systems of Brevard, Inc.

   MAILING ADDRESS: 486 Gus Hipp Blvd

   CITY Rockledge COUNTY Brevard

   ZIP CODE: 32955 BUSINESS PHONE: 321-633-7050

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

   Private

3. MANAGER'S NAME: Brooke Taylor

   ADDRESS: 486 Gus Hipp Blvd, Rockledge, FL 32955

   PHONE #: 321-633-7050 Ext: 100

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
Monica Van Leeuwen	486 Gus Hipp Blvd, Rockledge, FL 32955	CFO
Brooke Taylor	486 Gus Hipp Blvd, Rockledge, FL 32955	CEO/President

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

NAME	ADDRESS	PHONE #
Brevard County Fire Rescue	1040 S. Florida Ave, Rockledge, FL 32955	321-633-2056
Health First	6450 US 1, Rockledge, FL 32955	321-434-4300
Parrish Medical Center	951 N. Washington Ave, Titusville, FL 32796	321-268-6111

6. FUNDING SOURCE: Medicaid, Medicare, Private Insurance & DRG-MOA

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

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

Base Station- 486 Gus Hipp Blvd, Rockledge, FL 32955

III. COMMUNICATIONS INFORMATION:

TYPES OF RADIOS/EQUIPMENT:

800MHZ & 400MHZ UHF/VHF

1. RADIO FREQUENCY (ies)

See Attached

2. RADIO CALL NUMBER(s)

See Attached

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

FROM AMBULANCE	FROM BASE STATION
All Agencies in Brevard County	All Agencies in Brevard County
All Hospitals in Brevard County	All Hospitals in Brevard County
including Sebastian RMC	including Sebastian RMC

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, _____, the representative of

Applicant Name

_____, 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, Brooke Taylor **, the representative of**

Applicant Name

Coastal Health Systems of Brevard, Inc. **, 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