



# 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:** 02/20/24

**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 COPCN 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.

**II. COMPANY DETAILS**

1. NAME OF AGENCY: 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):

| <u>NAME</u>        | <u>ADDRESS</u>                        | <u>POSITION</u> |
|--------------------|---------------------------------------|-----------------|
| 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

| <u>NAME</u>            | <u>ADDRESS</u>                             | <u>PHONE #</u> |
|------------------------|--|----------------|
| Brevard 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: Medicare, Medicaid, Private Insurance, & DRG-MOA

7. RATE SCHEDULE ATTACHED? YES  NO  N/A

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

Base Station - 486 Gus Hipp Blvd Rockledge, FL 32955

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**III. COMMUNICATIONS INFORMATION:**

TYPES OF RADIOS/EQUIPMENT:

800MHZ & 400MHZ UHF/VHF

1. RADIO FREQUENCY (ies)

2. RADIO CALL NUMBER(s)

See Attached

See Attached

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

FROM AMBULANCE

All Agencies in Brevard County

All Hospitals in Brevard County

including Sebastian RMC

FROM BASE STATION

All Agencies in Brevard County

All Hospitals in Brevard County

including Sebastian RMC

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

**RENEWAL APPLICANTS NEED ONLY #'s 4 - 9**

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 Incl: Service Type, Base Rate, Mileage, Waiting & Special Charges

V. NOTARIZED STATEMENTS

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.

Brooke Taylor 2/20/2024  
APPLICANT SIGNATURE DATE

Before me personally appeared the said Brooke Taylor 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 20th day of February, 2024

[Signature]  
NOTARY PUBLIC

My commission expires: 06/06/24



FELICIA B. DEVOE  
Commission # GG 984937  
Expires June 6, 2024  
Bonded Thru Budget Notary Services