FORM 3: AMBULANCE OPERATING ZONE SUMMARY FORM

Date:

Local EMS Agency or County Name:

Area Description: *(e.g,. Zone 1, Zone A)*

Title:

Geographic Description: *(Also attach map)*

Current Provider Name: *(include legal, fictitious, and dba)*

☐ **Exclusive** ☐ **Non - Exclusive**

Type of Exclusivity (HSC § 1797.85): *(Check all applicable boxes)*

☐ **Emergency Ambulance**

☐ **Advanced Life Support (ALS)**

☐ **Limited Advanced Life Support (LALS)**

Scope of Operations: *(Check one box)*

☐ **9-1-1 Emergency Ambulance**

☐ **7-Digit Emergency Ambulance**

☐ **ALS Ambulance**

☐ **All ALS Ambulance Services**
(9-1-1, 7-Digit, IFT)

☐ **All CCT/ALS Ambulance Services**
(CCT, 9-1-1, 7-Digit)

☐ **BLS Non-Emergency Services**
(IFT)

☐ **Critical Care Transport**

☐ **Standby Service with Transport Authorization**

☐ **All Emergency Services**
(9-1-1, 7-Digit, IFT, CCT, Non-Emergency, Standby Transportation)

☐ **Other**

_____

_____

_____

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Method to Achieve Exclusivity, if applicable (HSC § 1797.224):

☐ **No Competitive Process:**

(If requesting to grant exclusivity without a competitive process for current providers, please complete the Non-Competitive Process EOA Provider Checklist and attach.) The LEMSA shall submit documentation, pursuant to §100450.59(c)(6)(A).

Provide a description of the ambulance dispatch process for the EMS area and subareas.

Provide a description of the system status management plan for the EMS area and subareas.

Provide a description of how ambulance service is provided to any portion of the EMS area not under the jurisdiction of the LEMSA due to Federal autonomy, which includes military bases, national parks, and some tribal reservations, pursuant to pertinent federal statute and state statutes.

☐ **Competitive Process:**

List contract dates_____.
(Submit a copy of the request for proposal and signed contract, if not previously submitted.)

If this information is unchanged and the plan has been previously approved by the EMS Authority, it is not necessary to re-submit.

Manner and Scope

Has there been any change in manner and scope since the last approved EMS plan?
(e.g., boundary changes, ownership changes)

☐ **Yes** *(Attach detailed explanation)* ☐ **No**

Appendix B – Non-Competitive Process EOA Provider Checklist (September 2009)

In accordance with Health and Safety Code section 1797.224, a local EMS agency may consider allowing EOAs to providers without a competitive process. Please complete the following documentation in support of a request to grant exclusivity to a provider without a competitive process. Any missing or incomplete submissions may affect the EMS Authority's ability to make a determination regarding eligibility.

1. Operating Area Name and Description:
(Attach map including adjacent zones.)

2. Has a competitive process ever been conducted in this area?

☐ **Yes** *(If yes, provide the following)* ☐ **No**

Provider: _____

Start Date: _____

Length of Agreement: _____

3. Type of Service:

☐ **Emergency** ☐ **ALS** ☐ **LALS**

4. Organization Name: *(include legal, fictitious, and dba)*

5. Address:

Headquarters: _____
_____

Operational: _____
_____

6. Type of Organization:

☐ **Corporation** ☐ **Partnership**

☐ **Public Agency** ☐ **Joint Powers Authority**

7. Month/Year Service Began:

8. Breaks in Service, if applicable:
(Include length of each break, reason, and how zone(s) were serviced during the break.)

9. Any change in zone boundaries/service area since January 1, 1981? If so, please provide the following:

a) Describe and include population affected:

b) Attach clearly labeled maps illustrating boundary changes.

c) Include call volume data for affected area(s) and list data source:

d) List any providers affected by the change:

e) Include prior call volume data and projected call volume following change.

10. Any change in ownership? For each change since January 1, 1981, please provide the following:

a) List changes in names:

b) List dates of ownership changes: *(Include all applicable copy of contracts and/or sale/transfer agreements.)*

c) Disposition of assets: Were all assets transferred to new owner(s)?

☐ Yes ☐ No *(If no, provide an explanation)*

d) Transfer of employees: Were all employees hired by new owner(s)?

☐ Yes ☐ No *(If no, provide an explanation)*

e) Disposition of accounts payable and receivable: Were accounts payable and receivable transferred?

☐ Yes ☐ No *(If no, provide an explanation)*

11. Since January 1, 1981, have any other providers served all or part of this zone? If so, please answer the following:

a) Are the providers currently in operation?

☐ Yes ☐ No

List all providers and their level of service: *(emergency, ALS, BLS)*

b) If the provider(s) no longer serve the area, list their level of service, dates of service, and reason for termination of service.