TEXAS Health and Human Services | Texas Department of State Health Services

EMS PROVIDER RENEWAL
WITH FEE PAYMENT
Revised 09/2024

For DSHS Use Only - ZZ100-160

*Remit Date*_____

*Remit No.*_____

*Amount Pd.*_____

EMS PROVIDER APPLICANT ADDRESSING INFORMATION: When sending EMS Provider/FRO Licensing submissions **that contain a fee payment,** please send to the appropriate address:

General Mail (US Mail):	**Overnight/Express/Parcel:**
Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 PO Box 149347 Austin, Texas 78714-9347	Texas Department of State Health Services (DSHS) Cash Receipts Branch – MC 2003 1100 West 49th St. Austin, Texas 78756-3101

Payment Submitted by (if different than applicant):	
Name of EMS Provider or FRO applicant:	
EMS Provider License Number:	
Applicant's Assumed Name or DBA (if applicable):	
Mailing Address:	
City, State, Zip:	
Payment Amount:	
Submission Date:	

If sending a USB drive, please insure the USB drive is securely fastened to a letter addressed to EMS Certification and Licensing Group, in case it is separated from the envelop in the mail room.

INTERNAL DSHS DELIVERY:
EMS Certification
Exchange Building – MC 1876

TEXAS Health and Human Services | Texas Department of State Health Services

EMERGENCY MEDICAL SERVICES PROVIDER LICENSE NOTIFICATION/CHANGES FORM

Revised 09/2024

As per 25 TAC, §157.11, EMS providers are responsible to submit to the Department of State Health Services any of the following notifications and/or changes within the time stated:

Submit this completed form along with the appropriate cover sheet.
Cover sheets contain the mailing/shipping address this form should be sent to and can be found at www.dshs.state.tx.us/emstraumasystems/provfro.shtm.

Fax Number: 512-834-6714 Email: EMSProviderFRO@dshs.texas.gov

EMS Provider Information

Name of Legal Entity _____

Legal Entity Assumed Name _____

Entity Address _____

City, State, Zip, County_____

License Number _____ Phone _____ Fax _____

☐ **Medical Director Change - within 1 business day**

New Medical Director Name _____ License Number _____

Resignation/Termination Date of Previous_____

Reason for Change: _____

Required Additional Documentation (All required):

☐ Attach Medical Director Information Form.
☐ Attach Medical Director Agreement/Contract.
☐ Attach electronic copy (CD or USB Flash Drive) of New Protocols and Equipment/Medication List.

☐ **Change in Declared EMS Administrator of Record (AOR) - within 5 business days**

Do not submit this form for a name change request, please submit a Personnel Name Change Form.

Previous Administrator's Name _____ SSN/EMS Certification # _____

New Administrator's Name _____ SSN/EMS Certification # _____

E-mail: _____ Business Phone: _____

Effective Date: _____

Required Additional Documentation:

☐ Attach EMS Provider Administrator of Record Information Form (Government Entities exempt).

☐ **Delete EMS Vehicle(s)**

Unit#_____ VIN #_____

Unit#_____ VIN #_____

Required Additional Documentation:

☐ Return the original vehicle authorization with this form (Certificate that is placed in vehicle).

☐ **Add EMS Vehicle(s)**

Required Additional Documentation (All required unless noted otherwise):

☐ Attach EMS Vehicle Form with only new vehicle(s) information.
☐ Attach Updated EMS Personnel Form, revised staffing plan and revised service area map (if applicable).
☐ Attach Certificate of Insurance for all EMS Vehicles operated by the provider (*Insurance cards carried in vehicle are not acceptable*).
☐ Attach Copy of vehicle title, vehicle lease agreement, registration receipt from the DMV, exempt registrations if applicant is a government subdivision, or an affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.
☐ Enclose Payment of $180 per additional vehicle for license with more than 12 months remaining before expiration date or $90 per additional vehicle for license with 12 months or less remaining before expiration date.
☐ Requesting Fee Exemption. Must complete Fee Exemption section on this form.

☐ **EMS Vehicle Substitution or Replacement - within 5 business days**

Old Vehicle: Unit#_____ VIN #_____ Type ___ LP _____Make_____ Year ____

New Vehicle: Unit#_____ VIN #_____ Type___ LP_____Make _____Year ____

Reason for Change: _____

Old Vehicle: Unit# _____ VIN #_____ Type___ LP _____Make_____ Year ____

New Vehicle: Unit#_____ VIN #_____ Type___ LP _____Make_____ Year ____

Reason for Change: _____

Required Additional Documentation (All required unless noted otherwise):

☐ Attach Certificate of Insurance for all EMS Vehicles operated by the provider.
☐ Attach EMS Vehicle Substitution/Replacement Form found at the end of this document **if replacing more than two vehicles**.
☐ Attach Copy of vehicle title, vehicle lease agreement, registration receipt from the DMV, exempt registrations if applicant is a government subdivision, or an affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.

☐ **Notification of Collision Involving In-Service and/or Response Ready EMS Vehicle - within 1 business day**

If there was a collision that resulted in vehicle damage whenever there was personal injury or death to any person.

Location of Accident _____ Date of Accident _____

☐ **Notification of Collision Involving In-Service and/or Response Ready EMS Vehicle - within 5 business days**

If a vehicle was rendered disabled and inoperable at the scene or there is a patient on board.

Location of Accident _____ Date of Accident _____

☐ **Change of Vehicle Authorizations – Must be approved for the level you want to change to.**

Authorization Level Changing From _____ Authorization Level Changing To _____

Number of authorizations being changed _____

Required Additional Documentation:

☐ Enclose Payment of $10 per authorization being changed and reprinted.
☐ Requesting Fee Exemption. Must complete Fee Exemption section on this form.

☐ **Change in Address of Physical Location**

Previous Address _____

Phone Number _____ Fax Number _____

New Address _____

Phone Number _____ Fax Number _____

Effective Date _____

☐ **Change in Mailing Address**

Previous Address _____

Phone Number _____ Fax Number _____

New Address _____

Phone Number _____ Fax Number _____

Effective Date _____

☐ **Change in Address for Location of Patient Report File Storage**

Previous Address _____

Phone Number _____ Fax Number _____

New Address _____

Phone Number _____ Fax Number _____

Effective Date _____

☐ **Change in Billing Address**

Previous Address _____

Phone Number _____ Fax Number _____

New Address _____

Phone Number _____ Fax Number _____

Effective Date _____

☐ **Change in Dispatch Address**

Previous Address _____

Phone Number _____ Fax Number _____

New Address _____

Phone Number _____ Fax Number _____

Effective Date _____

☐ **Upgrade or Downgrade in Level of Service - within 5 business days**

This only applies if provider is not currently approved to operate at the new level of service

Previous Level of Service _____ New Level of Service _____ Desired Effective Date _____

Required Additional Documentation (All required unless noted otherwise):

☐ Attach Protocols (CD or USB Flash Drive) for review.
☐ Attach Equipment/Medication List (CD or USB Flash Drive) for review.
☐ Attach Updated Employee Form for review (if upgrading).
☐ Attach Updated EMS Vehicle Form.
☐ Enclose Payment of $30 for each vehicle being changed to a new level of service.
☐ Requesting Fee Exemption. Must complete Fee Exemption section on this form.

☐ **Change in Declared Service Area - within 5 business days**

Does EMS Provider provide 911 Service? ☐Yes ☐ No
Will this Change affect 911 Service? ☐ Yes ☐ No
If yes, will the EMS Provider continue to provide 911 service in any service area? ☐ Yes ☐ No ☐ N/A

Required Additional Documentation (All required unless noted otherwise):

☐ Attach 911 Service Area contract (if applicable)
☐ Description of new service area is attached (City & County).
☐ Attach List of Station Locations: ☐ Station Additions ☐ Station Deletions
☐ Does this change affect the Protocols? ☐ Yes ☐ No ☐Attach Protocols (if applicable)

☐ **Subscription Services: Notification of Advertisements - within 10 days after beginning of any enrollment period**

☐ Attach Copy of advertisement. Enrollment Period Date _____

☐ **Requesting Fee Exemption – Only complete this section if provider is exempt from fees Government Entities cannot claim fee exemption**

I, _____, certify that the above named entity meets the following provisions of 25 TAC, Chapter 157: 1) provides emergency pre-hospital care, 2) operates with at least **75% volunteer personnel**, 3) have no more than **five full-time paid staff or equivalent** and 4) the firm is recognized as a **Section 501 (c)(3) nonprofit corporation by the Internal Revenue Service.**

Name and Signature of Applicant, Owner or Authorized Agent, Date

On behalf of the above named legal entity, to the Texas Department of State Health Services, I hereby affirm and declare that all information submitted on this form and attached supplemental documents are true and correct. It is understood that any false information given or misrepresentation made in this application or other requested documents may result in revocation or denial of license. I have read, understand, and agree to abide by Chapter 773 of the Texas Health and Safety Code and Title 25 of the Texas Administrative Code, Chapter 157.

_____ _____

Signature of Applicant, Owner or Authorized Agent

Printed Name of Applicant/Authorized Agent/ Title
(Must be owner if a change in EMS Administrator)

Email Address _____

Date: _____ Phone: _____

PRIVACY NOTIFICATION

With a few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for information on Privacy Notification. (Reference Government Code, Section 552.021, 552.023 and 559.004)

TEXAS Health and Human Services | Texas Department of State Health Services

EMERGENCY MEDICAL SERVICES PROVIDER LICENSE
EMS VEHICLE SUBSTITUTION FORM
REVISED: 09/2024

As per 25 TAC, §157.11, EMS providers are responsible to submit to the Department of State Health Services any of the following notifications and/or changes within the time stated:

EMS Vehicle Substitution or Replacement (**within 5 business days**)

1. Attach Certificate of Insurance for all EMS Vehicles operated by the provider.
2. Attach EMS Vehicle Substitution/Replacement Form more than one vehicle.
3. Attach Copy of vehicle title or vehicle lease agreement or exempt registrations if applicant is a government subdivision or affidavit identifying applicant as the owner, lessee, or authorized operator of new vehicle.

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____

Old Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
New Vehicle: Unit#_____ VIN #___________________ Type___ LP_______ Make_______ Year ____
Reason for Change: ____