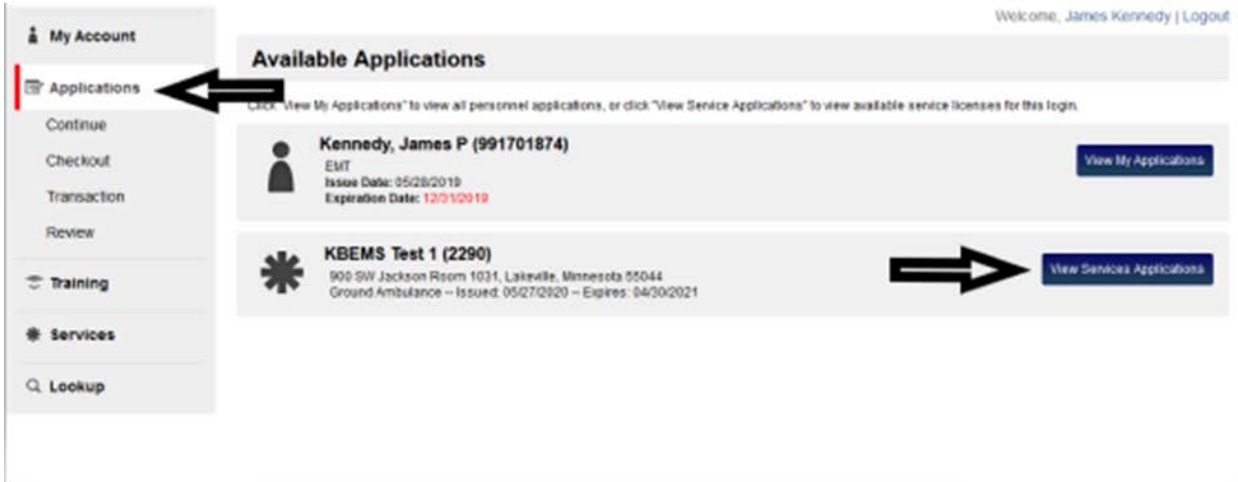


# Ambulance Service Permit Renewal

Renewal applications are only available in the KBEMS Portal from February 1<sup>st</sup> through April 30<sup>th</sup> of each year. All ambulance services must renew their Service Permit each year. Services applications are normally only available to Service Directors, Assistant Service Directors, and those in a designated Administrative Position. To view services applications, click “Applications” and then “View Services Applications” for your Service.



To access the “Ambulance Service Permit Renewal” Application, click “Apply Now” next to that application in the Service Applications section of the portal.

**Ambulance Service Permit Renewal**

Ambulance Service Permit Renewal. This application is to renew only your ambulance service permit. You will need to complete a ground and or air ambulance license application in addition. You can run both application processes at the same time, but both the service renewal and your ambulance license renewals **MUST** be completed for your annual renewal process.

[Apply Now](#)

275 days until application period closes

Click Save and Continue as you complete each page.

< **Instructions** Owner Operator Service Director Service Information Service Response Data Service Personnel Service S > ▾

▼ **Instructions**

**Completion of this application is required to gain initial or renewal of an ambulance service license. Remember that the payment must accompany the application to be considered a complete application.** Once the form is completed and submitted, if you need to make a payment by check please submit the check via mail and include a letter regarding the reason for the payment so that it may be appropriately applied.

\*\*\* NOTE: It is recommended you complete all information in the application and save your work, but do not submit until you have printed the attached forms and acquired signatures. Once this is completed, upload the documents in the areas needed and then submit. You can wait to make your payment until you have completed all required information for each of your ambulances on the Ground or Air Ambulance License request. The system will allow you to pay for all at one time. If you have questions please call James Reed directly. 785-640-4259

This application and the required information are pursuant to K.S.A 65-6127(a), K.S.A 65-6127(b), K.S.A 65-6127(c), K.A.R 109-2-2(a)(1), K.A.R 109-2-2(h), K.A.R 109-2-2(i), K.A.R 109-2-2(j), K.A.R 109-2-2(k), K.A.R 109-2-2(l).

Incorrect or incomplete information or failing to make payment will result in delay in issuing service license. **This must be completed before April 30th**

If you have any questions, please contact James Reed directly at 785-640-4259 or email [james.reed@ks.gov](mailto:james.reed@ks.gov).

[Save and Continue](#)



## Update/Complete the Owner section of the application:

10-100 Ambulance Service Permit Request 2020

Instructions Owner Operator Service Director Service Information Service Response Data Service Personnel Service

Owner Information

\*Permit Type  
 Ground Ambulance  
 Air Ambulance

The questions below are required for the service renewal application. Please select yes or no as the service lines you provide to your community. Selecting yes does not mandate you will provide the service 100% of the time, it is simply that you can and do provide these service lines. For clarification specific to Mobile Integrated Health / Community Paramedic, this is for a specific designated program, this would not include items like a lift assist to residents. Again, select yes or no for each item in this section.

\*911/Scene Response (with transport capabilities)  
Select 911/Scene Response (with transport capabilities)

\*911/Scene Response (without Transport Capabilities)  
Select 911/Scene Response (without Transport Capabilities)

\*ALS Intercept  
Select ALS Intercept

\*Critical Care (Ground)  
Select Critical Care (Ground)

\*Event Standby  
Select Event Standby

\*Interfacility Transfers (Hospital to Hospital)  
Select Interfacility Transfers (Hospital to Hospital)

\*Medical Transport (Convalescent, Hospital to Nursing Home, Hospital to Home, etc.)  
Select Medical Transport (Convalescent, Hospital to Nursing Home, Hospital to Home, etc.)

\*Mobile Integrated Health / Community Paramedicine (Specific designated program)  
Select Mobile Integrated Health / Community Paramedicine (Specific designated program)

\*Non-emergent Medical Transportation  
Select Non-emergent Medical Transportation

\*Public Education (CPR, Stop-the-Bleed, Fall Risk Assessment, Injury Prevention, etc.)  
Select Public Education (CPR, Stop-the-Bleed, Fall Risk Assessment, Injury Prevention, etc.)

\*Rescue  
Select Rescue

\*Tactical EMS  
Select Tactical EMS

\*Service Name  
KBEMS Test 1

Service Number  
99991

\*E-mail Address  
james.kennedy@ks.gov

\*Organization Type  
Governmental, Non-Fire

\*Organization Status  
Combination

Federal Tax ID Number

Street 1  
900 SW Jackson

Street 2  
Room 1031

\*Postal Code  
06612  Lookup

\*City  
Topeka

County  
Shawnee

State  
Kansas

Phone

Fax

\*Owner Name

Street 1

Street 2

Postal Code

City

State

Phone

Fax

\*Owner Email

Don't Forget to Click "Save And Continue" at the end of the page.

If the Operator of the Service is different than the Owner, Complete the Operator Section”

**▼ Operator Information**

\*Does the owner of the service also operate the service?

Yes

No

Operator Name

Operator Address 1

Operator Address 2

Operator City

Operator State

Operator Postal Code

Operator Phone Number

Operator Email address

\*Is the ambulance service owned by a corporation?

Yes  No



If the service is owned by a corporation, complete and attach that form:

On the form provided, please complete the requested information regarding Corporation information here in the application, as it is a fillable pdf. form must be printed for a signature from a corporate officer. You may save it as a document on your computer and upload it in the area provik below. The document type will be indicated as "Supporting Documentation".

### Corporate Information upload

Click [Corporate Information](#) to complete the required form. After you are completed with the form, make sure that once you have uploded the f [click add](#) prior to save and continue.

#### Corporate Information

Name

Document Type

Complete the Service Director Information:

< [Instructions](#) [Owner](#) [Operator](#) **[Service Director](#)** [Service Information](#) [Service Response Data](#) [Service Personnel](#) [Service](#) >

▼ Service Director

\*Service Director Name

\*Service Director address

\*City

\*State

\*Zip code

\*Primary phone number

\*Email address

## Complete the Service Revenue/Expense Section:

### Service Revenue / Expense

- Please complete the following questions for your service or agency.
- Answers are to be completed in a dollar format 0000.00
- Please do not use commas or you will encounter validation errors.

\*What was the service's tax subsidy for the previous year?

\*What was the previous years revenue (user fees) collected?

Previous years revenue include Medicare, Medicaid, third party insurance or private payments. This does not include donations or tax subsidies

\*Other revenue collected (i.e. Capital equip., gifts, endowments etc.)

\*What were the total expenditures for the previous year?

Note: Fire Departments, this is only in regards to your EMS budget.

**What are your current charges for the following:** The following information is to be represented in dollar amounts. If there is no charge it will be represented by 0.00

\*BLS Non-Emergency

\*BLS Emergency

\*BLS Mileage Charge

\*ALS, Level 1 Non-Emergency

\*ALS, Level 1 Emergency

\*ALS Mileage Charge

\*Fixed wing base rate

\*ALS, Level 2

\*Specialty Care Transport

\*Fixed wing Mileage

\*Rotor wing Base Rate

\*Rotor wing Mileage

\*Mileage rates are based upon:

\*Does your service charge for supplies?

Complete the Service Response Data Section:

< Instructions Owner Operator Service Director Service Information **Service Response Data** Service Personnel Service >

Service response data

\*Is your service ALS capable? (Personnel and equipment resources with ALS protocols are in place)

Select Is your service ALS capable? (Personnel and equipment resources with ALS protocols are in place) ▼

If YES to the above question, does your service have ALS capabilities for:

Select If YES to the above question, does your service have ALS capabilities for: ▼

\*Did your service report to the KEMSIS System for the previous calendar year?

Yes

No

\*What is the total population in the area you serve?

\_\_\_\_\_

List all agencies that provide **emergency medical services** with your ambulance service. You MUST indicate if each of the agencies utilize your EMS Protocols. This includes all Fire Departments, Organized First Response or Industrial agencies etc.. In the box below, list each agency with protocol usage. Answer on separate lines for each agency.

\_\_\_\_\_

Save and Continue

...and the Service Personnel Section:

< Instructions Owner Operator Service Director Service Information Service Response Data Service Personnel Service >

Service Personnel

\*Have you verified / updated your service roster in License Management public portal so that it reflects your current staffing?

Select Have you verified / updated your service roster in License Management public portal so that it reflects your current staffing?

\*Service Director

Select Service Director

\*Assistant Service Director

Select Assistant Service Director

\*Instructor Coordinator

Select Instructor Coordinator

\*How many Instructor Coordinators do you have in your service?

Below, indicate the total number of personnel in your service in the categories represented (Please include the Service Director and Assistant Director in your count). When indicating Volunteer, remember Volunteers receive no compensation, only reimbursement for expenses.

\*Total Full time personnel

\*Total Part time personnel

\*Total Volunteer personnel

\*How many Allied Health personnel do you have in your service?

Are all of your services Allied Health Personnel registered with the Kansas Board of EMS?

Yes  No

\*Does your service have adequate personnel resources?

Select Does your service have adequate personnel resources?

Save and Continue



And the Service Survey (some questions only appear as a result of Yes answers to certain questions).

[< on](#) [Service Response Data](#) [Service Personnel](#) **[Service Survey](#)** [Medical Director Appointment / Approved Equipment list](#) [EMS Protocol](#)

▼ **Service Survey**

\*Is your service involved with the EMS Regional Council?  
 Yes  No

\*Does your service receive any type of resources from the Regional EMS Council?  
 Yes  No

\*Does your service have adequate access to training opportunities and resources?  
 Yes  No

\*Are you satisfied with the knowledge of newly certified attendants?  
 Yes  No

\*Does your service utilize blood glucose monitoring (BGM)?  
 Yes  No

\*Does your service have a current Clinical Laboratory Improvement Amendment (CLIA) waiver for BGM?  
 Yes  No

\*Were any of your Service's ambulances involved in any MVC's in the past 12 months?  
 Yes  
 No

Was the MVC Non-injury?  
 Yes  
 No

Was the MVC Injury/ Fatality?  
 Yes  
 No

Enter the Medical Director Information. If the Medical Director has changed and you have not yet submitted the Medical Director Assignment form, complete and attach that form as well as the approved equipment list.

**Medical Director Information**

\*Medical Director Name

Medical Directors License number

\*Medical Directors Area of Specialty

**Medical Director Appointment**

\*Has your Medical Director changed in the last 12 months?

Yes  
 No

\*Have you submitted the required Medical Director form with the appropriate signatures since that change?

Yes  
 No

You have indicated your Medical Director has changed. Below you will find a Medical Director Appointment form. Please complete the form here in the application as it is a fillable pdf, print it off to obtain the Medical Directors signature and upload it to this application prior to submission. Your document type will be indicated as a "Supporting Document".  
\*\*\*Please remember in the event your Medical Director does change, our office needs to be notified of this change within ten (10) days of the occurrence.

Click Medical Director Appointment to complete the form. After you are completed with the form, make sure that once you have uploaded the form [click add](#) prior to save and continue.

Medical Director Appointment form

Name

Description

Document Type

Supporting Documents

**Approved Equipment List**

Approved equipment list must be submitted annually as required by regulation K.A.R. 109-2-2(h)(2):  
Each operator submits the list of supplies and equipment carried on each ambulance validated by the signature of the ambulance service's medical director to the board each year with the operator's application for an ambulance service permit.

\*Approved equipment list

\*Name

\*Description

Document Type

Supporting Documents

Also upload the EMS Protocol Approval Letter:

10-100 Ambulance Service Permit Request 2020

Case Data Service Personnel Service Survey Medical Director Appointment / Approved Equipment list EMS Protocol Approval Ac > v

EMS Protocol Approval

**EMS Medical Protocols must be approved as follows, as required by regulation K.A.R. 109-2-5(u):**  
(u) Each ambulance service operator shall adopt and implement medical protocols developed and approved in accordance with K.S.A. 65-6112, and amendments thereto. **The medical protocols shall be approved annually and defined in K.S.A. 65-6112(r):**  
(r) "Medical protocols" mean written guidelines which authorize attendants to perform certain medical procedures prior to contacting a physician, physician assistant authorized by a physician, advanced practice registered nurse authorized by a physician or professional nurse authorized by a physician. **The medical protocols shall be approved by a county medical society or the medical staff of a hospital to which the ambulance service primarily transports patients,...**

\*EMS Protocol Approval Letter

\*Name

\*Description

Document Type  
Supporting Documents

Enter your initials and password and click "Submit" to complete the application.

10-100 Ambulance Service Permit Request 2020

Personnel Service Survey Medical Director Appointment / Approved Equipment list EMS Protocol Approval Acknowledgement > v

Acknowledgement

As the appointed representative of the organization, I assure and certify that the organization understands and is in compliance with the authority and requirements of an Ambulance Service as described in Kansas statutes annotated and Kansas administrative regulation. I declare under the penalty of perjury under the laws of the State of Kansas that the information provided in this application are true and correct to the best of my knowledge.

\*Enter the Service Directors initials in the box below acknowledging the statement above.

Username: jkennedy  
Password: