New York State Department of Health
Bureau of Emergency Medical Services

Funding Document For EMS Agencies

Please complete the following information regarding the funding of your agency.

NOTE: Response is mandatory. Failure to complete this form accurately may impact your agency's authority to collect fees for prehospital patient care.

Name of EMS agency _____ DOH agency code _____

Does your EMS agency bill (collect fees for prehospital transport/patient care)?
☐ Yes ☐ No

If Yes, does your agency process its own billing and filings to Medicare/Medicaid/private insurance for prehospital transport/patient care fees?
☐ Yes ☐ No

If Yes, skip to Funding Sources section below.
If No, indicate the name of the "Service Bureau" or contractor that processes the billing for your EMS agency

EMS Agency NYS Medicaid provider ID number _____

Service Bureau NYS Medicaid ID number _____
Note: if your contractor also provides EMS, the Service Bureau is not the same ID used by that EMS agency for its own billing, or your ID this is a separate ID number issued to the contractor by Medicaid authorizing the contractor to process/submit billing for 3rd party EMS agencies.

The New York State Department of Health will assume that failure to provide a valid ID number for a Medicaid Service Bureau indicates that your service's billing practices and/or contractor services are unlawful and will report them to the New York State Office of Health Insurance Programs.

Funding Sources

Identify ALL of the funding sources received by your EMS agency.

☐ Fire District(s)[NOT fire protection districts] _____
(If more than one district, list additional on back of this page. List Fire Protection Districts below)

☐ Ambulance District [legal name of taxing district] _____
(If more than one district, list additional on page 2)

☐ Municipal Contracts [other than fire districts] _____
(List all municipalities your agency holds EMS contracts with including County, City, Town, Village, and Fire Protection Districts.
List additional municipalities on page 2)

☐ Donations or fund-raisers _____

☐ Not-for-profit status
☐ 501(c)(3) ☐ Other NFP _____

☐ Other funding sources not identified above _____
(Include agreements/contracts with service fees to provide ALS to other certified services. i.e., ALS assists)

☐ Service's approximate total annual EMS operating budget _____

☐ Is your service an operator for another service that bills?
☐ Yes ☐ No

If Yes, service name _____ Agency code _____

Name of person completing this form _____
(print)

Title of person completing form _____ Date completed _____
(print)

Signature of person completing this form _____ Date _____

Additional Funding Information

Designate type of funding source as defined on page 1.