SILVER CROSS EMERGENCY MEDICAL SERVICES SYSTEM

TITLE: **AGENCIES REPORTING DOWNGRADING LEVEL OF CARE OR AMBULANCES TAKEN OUT-OF-SERVICE**

POLICY:

The purpose of System agencies reporting a lengthy temporary down grading in their level of service or reasons an ambulance is removed from service are to ensure compliance with rules and regulations of the State. Failure to report such events is a breach of the System plan. When a System agency alters its original proposal by downgrading the level of service or an ambulance is taken out of service for a non-routine/maintenance normal length of time, the System must be notified of such occurrences.

I. Downgrading Service Level or Ambulance Removed from Service (between 10-30 days)

A. The System must be notified by the following method:

1. Complete "Out-Of-Service" form and fax to EMS Office at 815-300-7917.

2. Once the level of service is returned to normal operational status or the ambulance is back in service, the notification process must be repeated.

II. Downgrading Service Level or Ambulance Removed from Service (30 days or more)

A. Agency must file a System Modification Form to the System, who informs the State

III. Repeated Offenses and Violations

All instances involving the downgrading of service level or out-of-service ambulance units by provider agencies will be logged and noted in the agency file. This program will be monitored to detect any problem areas, trends or a progression of patterns. A record of repeated events or failure to report such items could lead to agency suspension by the System. The state will be notified of such action. Each instance will be reviewed on a case-by-case basis.

EFFECTIVE DATE: 12-01-93
REVISED DATE: 11-22-11
REVIEWED DATE:

ATTACHMENT: **Out-Of-Service / Downgrade Form**

SILVER CROSS EMS SYSTEM
NOTIFICATION OF OUT-OF-SERVICE AMBULANCE

DATE: _____/_____/_____ TIME:_____HOURS

AGENCY:_____

PERSON COMPLETING REPORT:_____

PHONE # YOU CAN BE REACHED AT:_____

VEHICLE INFORMATION:

LICENSE #_____-_____-_____

VIN # _____ _____ _____ _____ (AT LEAST THE LAST 4)

LEVEL OF SERVICE: ALS BLS ILS A/D

DURATION OF TIME TO BE OUT-OF-SERVICE:

(_____) HOURS (_____) DAYS (_____) UNKNOWN

REASON FOR TAKING THE AMBULANCE OUT-OF-SERVICE:

(_____) ACCIDENT (_____) MAJOR REPAIR (_____) LOANED TO: _____

OTHER: (EXPLAIN)_____

CONTIGENCY PLAN (HOW DO YOU PLAN TO MAINTAIN LEVEL OF SERVICE)_____

COMMENTS:_____

BACK IN SERVICE

DATE:_____/_____/_____ TIME:_____HOURS

PERSON COMPLETING REPORT:_____

NAME OF SCEMSS EMPLOYEE RECEIVING REPORT: (SIGN BELOW)