

AGENDA PLACEMENT FORM

(Submission Deadline – Monday, 5:00 PM before Regular Court Meetings)

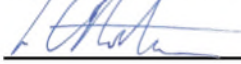
Date: 07.12.2024

Meeting Date: 07.22.2024

Submitted By: Lance Anderson

Department: Purchasing

Signature of Elected Official/Department Head:



Court Decision: <small>This section to be completed by County Judge's Office</small>
 <p>July 22, 2024</p>

Description:

Consider and Approve award of RFP 2024-303 for Paramedic Care and Ambulance Services to CareFlite.

(May attach additional sheets if necessary)

Person to Present: Lance Anderson

(Presenter must be present for the item unless the item is on the Consent Agenda)

Supporting Documentation: (check one) PUBLIC CONFIDENTIAL

(PUBLIC documentation may be made available to the public prior to the Meeting)

Estimated Length of Presentation: 15 minutes

Session Requested: (check one)

Action Item Consent Workshop Executive Other _____

Check All Departments That Have Been Notified:

- County Attorney IT Purchasing Auditor
- Personnel Public Works Facilities Management

Other Department/Official (list) _____

**Please List All External Persons Who Need a Copy of Signed Documents
In Your Submission Email**



3110 S. Great Southwest Pkwy.,
Grand Prairie, TX 75052
Phone: 972.339.4200
Email: BCrane@CareFlite.org

Request For Proposal for Paramedic Care and Ambulance Services for Johnson County

RFP 2024-303

Due Date: May 30, 2024 by 2:00 PM

CONFIDENTIAL DOCUMENT

Johnson County
411 Marti Drive,
Cleburne, TX 76033
(817) 556-6382

www.johnsoncountytexas.org



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I. Executive Summary

CareFlite is pleased to have the opportunity to respond to the Request for Proposal for Paramedic Care and Ambulance Services for Johnson County. CareFlite has been in business for nearly 45 years providing Air and Ground Emergency Medical Services. More specifically, our ground EMERGENCY MEDICAL SERVICE division has been providing services for over 43 years in North Texas, over 21 of which have been dedicated to serving citizens in a 911 capacity. In that time, CareFlite has provided care to over 1,255,000 patients in the DFW area. CareFlite was honored to provide emergency medical services in Johnson County from October 1, 2003 to October 1, 2017. A review of the system's performance from the records regularly provided to the county during that time make it clear that we have an established history of serving the county through superior patient care, quality customer service and on-time performance with a 90% or better compliance rate. The high level of patient care is due in part to the leadership of the company's Medical Director who also directs a level one trauma center, has received numerous national awards for his work in prehospital care and who is the only Emergency Medical Service Medical Director serving on the Texas Medical Control Board. CareFlite has over 650 employees in the DFW Metroplex, led by a Board of Directors from our sponsoring facilities including Texas Health Resources, Methodist Health Systems, Baylor Scott and White Healthcare System, JPS Health Network, and Parkland.

A 501(c)3 sponsored by the major nonprofit and public hospital systems in the region (including Texas Health Cleburne), the company is fully integrated into the trauma system. CareFlite has also provided significant other community health initiatives without cost to the County or its residents. The company operates to meet its mission of bringing help and hope to the communities we serve by providing unequalled and compassionate care. Because CareFlite is the primary provider for Hill County and the preferred secondary provider for both the Cities of Cleburne and Burleson, it is poised and equip to provide additional county support when needed. CareFlite's values, career pathing and longevity provide an excellent platform for retaining quality employees. CareFlite provides multiple avenues for internal development in the form of an initial EMERGENCY MEDICAL TECHNICIAN program, paramedic course sponsorship, and a mentor program that provides a bridge from ground services to air medical. CareFlite actively participates in community development in the areas it serves through an outreach program. CareFlite's Caring-Heart Membership Program currently provides coverage for 184,000 citizens of the DFW area, 20,895 of which reside in Johnson County. People are the strength of our organization and as such, we devote tremendous resources to provide a safe, comfortable work environment so that our employees are focused on what they do best, patient care. We provide monthly topics on smoking cessation, weight loss, exercise and management of other health related issues in an effort to inspire thought and action by our employees to become stronger, healthier individuals.

CareFlite acknowledges and accepts all the requirements in the Request for Proposal 2024-303. CareFlite's current system provides the basis for responding to your request. CareFlite currently operates a fleet of 100 ambulances outfitted with state-of-the-art equipment. CareFlite's providers operate utilizing advanced, evidence-based protocols that meet and exceed current industry standards. With CareFlite's experience, expertise, and resources, it is uniquely positioned to meet the requirements

of this Request for Proposal. As a non-profit organization, CareFlite puts the needs of the community and patients ahead of financial profits and gains. It is CareFlite's honor and privilege to submit the included response to the Request for Proposal for Paramedic Care and Ambulance Services for Johnson County 2024-303.

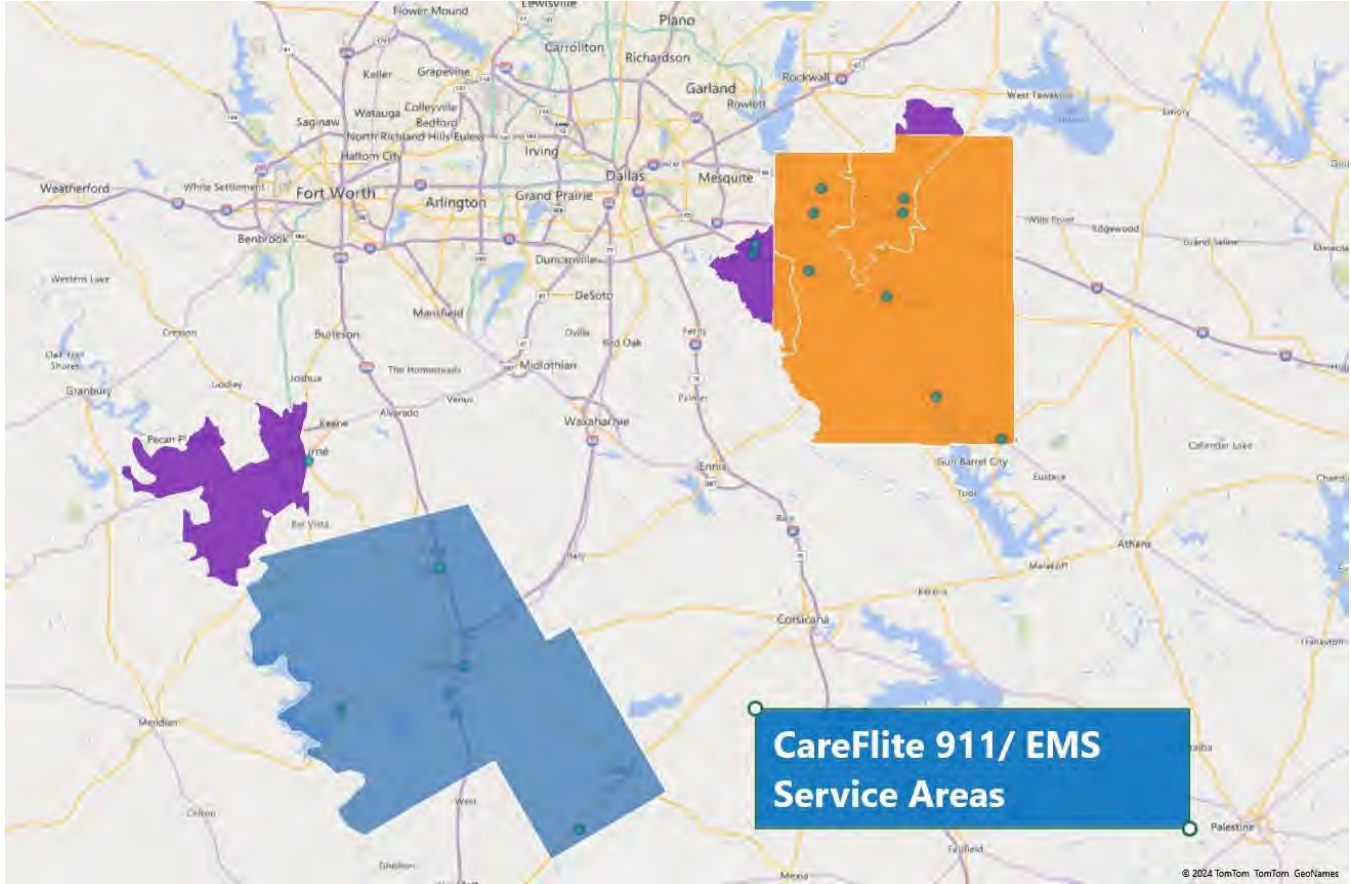
II. Minimal Experience Qualifications

A. Emergency Operating Area

CareFlite is vested in providing Johnson County with 24 hours per day, 7 days a week service. CareFlite does not withhold service to any individual regardless of socioeconomic status or ability to pay for service.

As indicated by the geographical image below, CareFlite's span of services covers many surrounding counties allowing for a collaborative and substantial resources pool.

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B. Financial Strength: (Refer to Appendix 2)

As evidenced in the financial statements presented in Appendix 3 and Appendix 4, CareFlite has adequate resources to meet the financial obligations in response to the Request for Proposal 2024-303.

C. Financial Statements: (Refer to Appendix 3 and Appendix 4)

As a 501(c)3, non-for-profit entity, CareFlite is financially separate from our sponsor facilities.

1. Balance Sheet
2. Income Statement
3. Statement of Cash Flow
4. Statement of Owner Equities

D. Audit Statement: (Refer to Appendix 3 and Appendix 4)

See pages 342 and 343 in Appendix 3 and pages 362 and 363 of Appendix 4 for an opinion of the audited financials.

E. Financial Obligations and Commitments: (Refer to Appendix 2)

F. Billing Operations:

CareFlite uses three external entities in billing; CentraSol, Diversified Healthcare Services and Golden Hour. CareFlite has high expectations of our vendors, performs frequent audits and all three vendors have been successful.

CentraSol is the primary vendor for ground billing and is owned and operated in Johnson County. Diversified Healthcare Services is the agency used by CareFlite to collect funds that are over ninety days. CareFlite has recently employed Golden Hour for the primary vendor air billing. There have been no significant findings against CareFlite by any government agency in regards to billing practices. CareFlite has not been sanctioned or settled in any class action lawsuits in reference to any discrepancies.

While more fully discussed in section I below, CareFlite's membership program currently protects 184,000 individuals and families throughout the DFW Metroplex. They are protected by the subscription program against balanced billing if insured. If uninsured, the program reduces the transport cost by 50 percent.

G. Description of Experience:

In addition to our success operating Hill County, Kaufman County, and the City of Seagoville, CareFlite previously operated contracts for emergency 9-1-1 services in the City of Balch Springs, Southeast Dallas County, and the City of Ferris. In addition to 911 services, CareFlite provides interfacility care for approximately 72,000 citizens as well as air medical services for approximately 3,600 citizens each year. The services provided range in need from basic life support to advanced and critical care.

H. Comparable Services:

Hill County CareFlite Emergency Medical Service Performance Metrics:

Approximately 986 square miles
Population ~ 37,329
Contract October 2009 – Present

Contact Information

Mr. Tad Duncan
President ESD #2
201 S. Outlet Dr.
Hillsboro, Texas 76645
254-498-0222
Taduncan1574@yahoo.com

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	3,416	579	555	90%
2023	3,497	505	580	90%

* Response time compliance goal: 90%

CareFlite assumed 911/Emergency Medical Services of Hill County, ESD #2 in October 2009. Again, this is a performance-based contract and the response time compliance is monitored closely. During the last almost 15 years of serving this region, CareFlite has relocated the ambulance stations to ensure that we are able to meet the needs of the community in a timely manner, reinforcing our commitment to providing timely safe, high quality emergency services. CareFlite offers a solid relationship with all volunteer departments’ providing any continuing education and assistance in obtaining First Responder Organization accreditation. Emergency Care Attendant classes were provided to the community free of charge to the First Responder Organization and firefighters.

Ellis County CareFlite Emergency Medical Service Performance Metrics:

5 square miles
Population ~ 2,893
Contract October 2009 - July 2023

Contact Information

Mr. Brooks Williams
City Manager
114 S. Central St.
Ferris, Texas 75125
972-544-2100
brookswilliams@ferristexas.gov

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	880	105	NA	99%
2023	951	118	NA	98%

* Response time compliance goal: 90%

CareFlite provided 911/Emergency Medical Service in Ellis County ESD #5 and Ferris, Texas from October 2009-July 2023. CareFlite provided this region with 1 M.I.C.U ambulance. This ambulance served the City of Ferris and a small portion of Ellis County. This region additionally had the support of CareFlite’s resources in Southeast Dallas County if the need arises. The area of Ellis County has developed at a slower rate than other areas in Ellis County therefore this area remains relatively rural.

Balch Springs CareFlite Emergency Medical Service Performance Metrics:

9 square miles
Population ~ 26,947
Contract October 2009 – October 2023

Contact Information

Dr. Carrie Gordon
Balch Springs Mayor
13503 Alexander Road
Balch Springs, Texas 75181
972-286-4477
cgross@cityofbalchsprings.com

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	2,710	755	NA	97%
2023	3,294	650	NA	95%

* Response time compliance goal: 90%

CareFlite provided 911/Emergency Medical Service in Balch Springs, Texas from October 2009-October 2023. CareFlite provided this region with 2 M.I.C.U ambulances. These ambulances served the City of Balch Springs. This region additionally had the support of CareFlite’s resources in Southeast Dallas County when the need arose.

Southeast Dallas County CareFlite Emergency Medical Service Performance Metrics:

63 square miles

Population ~ 2000

Contract January 11, 2012-May 2023

Contact Information

Mr. Robert De Los Santos
Southeast Dallas County Fire Marshall
509 Main St Records Building 3rd floor #310
Dallas, Texas 75202
214-653-7970
Robert.delossantos@dallascounty.org

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	257	37	NA	97%
2023	188	19	NA	97%

* Response time compliance goal: 80%

CareFlite provided 911/Emergency Medical Service in Southeast Dallas County, Texas from January 11, 2012-May 2023. CareFlite provided this region with 1 M.I.C.U ambulance. This ambulance served the unincorporated parts of Southeast Dallas County. This region additionally had the support of CareFlite’s resources in Balch Springs when the need arose.

Kaufman County:

807 square miles

Population ~ 172,366

Contract March 1, 2015-Present

Contact Information

Mr. Steve Howie
Emergency Management Coordinator
100 W. Mulberry St
Kaufman, Texas 75142
(469) 652-4040
stevehowie@kaufmancounty.net

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	11,029	1,928	1,102	90%
2023	11,430	2,029	479	90%

* Response time compliance goal: 90%

CareFlite has provided 911/Emergency Medical Service in Kaufman County, Texas from March 1, 2015 to present. CareFlite provides this region with 8 M.I.C.U ambulances. These ambulances serve these cities in Kaufman County separate from Terrell and Kaufman. This region additionally has the support of CareFlite’s resources in the Cities of Terrell, Kaufman, Seagoville, and Dallas when the need arises.

City of Terrell:

23 square miles
Population ~ 20,050
Contract March 1, 2015-Present

Contact Information

Mr. Mike Sims
City Manager
201 East Nash St.
Terrell, Texas 75160
(972)-551-6600
mikesims@cityofterrell.org

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	3,315	741	112	95%
2023	3,794	763	85	95%

* Response time compliance goal: 90%

CareFlite has provided 911/Emergency Medical Service in the City of Terrell, Texas from March 1, 2015 to present. CareFlite provides this region with 2 M.I.C.U ambulances. These ambulances serve the City of Terrell. This region additionally has the support of CareFlite’s resources in Kaufman County, the City of Kaufman, and Seagoville.

City of Kaufman:

9.22 square miles
Population ~ 8,388
Contract March 1, 2015-Present

Contact Information

Mr. Mike Holder
City Manager
209 S. Washington
Kaufman, Texas 75142
(972) 932-2216 ext. 109
mholder@kaufmantx.org

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	1,255	259	1,885	96%
2023	1,292	258	1,500	93%

* Response time compliance goal: 90%

CareFlite has provided 911/Emergency Medical Service in Kaufman, Texas from March 1, 2015 to present. CareFlite provides this region with 2 M.I.C.U ambulances. These ambulances serve the City of Kaufman. This region additionally has the support of CareFlite’s resources in Kaufman County, and the Cities of Seagoville and Terrell when the need arises.

City of Seagoville:

19.05 square miles
Population ~ 20,050
Contract June 1, 2022-Present

Contact Information

Mr. Patrick Stallings
City Manager
702 N. Highway 175
Seagoville, Texas 75159
(972) 287-2050
pstallings@seagoville.us

	Emergency Responses	Non-Emergency Responses	Interfacility	Response Compliance
2022	724	110	NA	94%
2023	2,059	329	NA	93%

* Response time compliance goal: 90%

CareFlite has provided 911/Emergency Medical Service in Seagoville, Texas from June 1, 2022 to present. CareFlite provides this region with 2 M.I.C.U ambulances. These ambulances serve the City of Seagoville. This region additionally had the support of CareFlite’s resources in Kaufman County, and the Cities of Terrell and Kaufman when the need arises.

I. Business Identification:

Prior to December 2006, CareFlite operated under the name of North Central Texas Services doing business as (dba) CareFlite. The name was officially changed to CareFlite in November of 2006.

J. Accreditation and Associations:

CareFlite is accredited by the Commission on Accreditation of Air Medical Services (CAAMTS) which includes our Specialty Care Ambulances (SCT) and the Communication Center is an Accredited Center of Excellence (ACE). CareFlite is an active member and participant of the North Central Texas Trauma Regional Advisory Council (NCTTRAC), the Heart of Texas regional Advisory Council (HOTRAC), the Capital Area Trauma Regional Advisory Council (CATRAC), the Governors Emergency Medical Services and Trauma Advisory Council (GETAC). We are also members of the Texas Ambulance

Association (TAA), the Association of Air Medical Services (AAMS), the Association of Critical Care transport (ACCT) and participate in Every Coast Helicopter Operations (ECHO) organization.

K. Insurance: (Refer to Appendix 11)

CareFlite meets all insurance requirements and will maintain those requirements throughout the life of the new contract.

L. Performance Security Requirements:

In its nearly 45 years of service, CareFlite has consistently provided high quality patient care and continuously met commitments to all communities served. Given the financial stability as demonstrated in the financial statement, CareFlite will consistently provide high standards for patient care into the future.

M. Outstanding/ Pending Litigation:

Please see the attached list of resolved or ongoing litigation where Careflite is a party within the past five (5) years. There is no litigation brought against or initiated by CareFlite against any governmental or competing ambulance service within the last five years. Please reach out for any additional information required. (Refer to Appendix 14)

III. Required Criteria

CareFlite understands and accepts all the required criteria.

A. Operational Expectations:

The Proposer shall provide and manage the delivery of emergency medical services by meeting or exceeding the requirements of this Request for Proposal and the resulting contract. The contract will be a performance contract, not level-of-effort contract; however, the following conditions are baseline expectations. The Proposer is highly encouraged to consider innovative methods to grow the service and exceed performance expectations.

CareFlite understands and accepts all the required criteria.

B. Staffing:

The Proposer is responsible for ensuring high-performance service through employing, managing, training and other personnel functions necessary to fulfill the terms of the contract.

1. Staff ambulance with a minimum of one (1) paramedic and (1) emergency medical technician.
2. Maintain personnel certifications and ambulance provider's license(s).
3. Ensure courteous, professional, and safe conduct of all personnel.
4. Ensure fair and safe shift schedules and employment practices.
5. Provide or purchase all in-service training of ambulance personnel.
6. Ensure clinical performance consistent with Department of State Health Services (DSHS) and Medical Director Standards and implement reasonable changes accordingly.

CareFlite understands and accepts all the required criteria.

C. Equipment:

The Proposer is responsible for ensuring high-performance service through employing, managing and maintaining all vehicular and medical equipment necessary to fulfill the terms of the contract.

1. Ambulance shall meet all requirements as set forth by the Texas Department of State Health Services, and must have affixed thereto the appropriate certification(s).
2. Equip each ambulance with all required personnel equipment and supplies for "Mobile Intensive Care Unit (MICU)" operations as required by the Texas Department of State Health Services and as further specified by the Proposer's Medical Director.
3. Ensure all motor vehicles used for the purpose of providing ambulance service hereunder, shall be designed to transport ill, sick or injured persons in comfort and safety, and shall be maintained in clean, sanitary, and good mechanical condition at all times, in compliance with any applicable State or Federal standards for ambulances.
4. All ambulances must be capable of transporting at least two (2) patients restrained on a long spine backboard, scoop stretcher, or similar movement restriction device.
5. Ensure ambulances and transport vehicles are mechanically sound and removed from service when appropriate to mitigate critical vehicle failures.
6. Ensure all mechanical, safety, and special equipment shall be subject to inspection at any reasonable time by representatives of the County.
7. Ensure no ambulance that has been substantially damaged or altered shall be again placed in service until it has been adequately repaired.
8. Furnish all fuel, lubricants, repairs, and necessary supplies.

CareFlite understands and accepts all the required criteria.

D. Community Relations:

The Proposer is responsible for ensuring high-performance service through employing good business practices, community partnerships and customer service to fulfill the terms of the contract.

1. Maintain and pay for Internet presence, telephone listings and/or advertising.
2. Maintain and support superior working relationships with air medical transport providers, medical first responders, law enforcement, and fire protection agencies.
3. Notify the County in a timely manner of all activities, issues, and policy/procedure modifications (internal and external) that may reasonably be expected to affect (positively or negatively) the County.
4. Ensure disaster readiness including strict compliance with the National Incident Management System (NIMS).
5. Participate in planning, exercises, and roles as assigned in Johnson County's Emergency Management Plan.
6. Participate in monthly meetings, planning, and improvement with public safety and fire partners.

CareFlite understands and accepts all the required criteria.

E. Communication System Requirements:

1. The Proposer will utilize industry standard radio communications, paging and alerting at all times. Johnson County's 700 megahertz trunked P25 radio system will be used for all Emergency Medical Service system operations communications. The proposer will be responsible for purchase, installation, repair and any replacement of the equipment. Technical specifications including make and model for additional units to ensure compatibility with the County's radio system will be provided by the County.
2. The Proposer will provide Emergency Medical Service dispatch services, including radio infrastructure, communications with First Responders and other emergency services. A communications plan must be approved by the County. 9-1-1 calls shall be provided by the Primary Service Answering Points (PSAPs) located in Johnson County and medical first response and fire service dispatch shall be provided by the Emergency Services District (ESD) PSAP.
3. Proposer will provide capability to record all medical radio traffic and to record emergency and non-emergency telephone calls and other communications with Proposer's dispatch center. [SEP]

4. Johnson County ESD uses SunGard Public Sector's ONE Solution Computer Aided Dispatch (CAD) (formally known as OSSI) and is transitioning to Soma Global. Proposer will be required to have suitable interface with the Johnson County CAD system for the ambulance service. It is required that proposers either maintain an active license to the ESD's CAD system with a fully functional station in the Emergency Medical Services PSAP or maintain an interface to allow real-time access to the ESD CAD data at their cost. Proposers shall describe how they will meet this requirement.

CareFlite understands and accepts all the required criteria.

F. Dispatch, Reporting, and Monitoring Operations:

The following represents the desired conditions for Emergency Medical Service dispatching when provided by the Emergency Medical Service proposer. Proposer shall describe how these desired conditions will be accomplished, including any exceptions or additions proposed.

1. A third party or sub-proposer dispatching provider will not be allowed without prior approval by Johnson County.
2. Proposer will receive calls for emergency ambulance service that are initially answered by a PSAP then transferred to Proposer.
3. Proposer may receive calls from PSAP via telephone, radio, or other mean.
4. Proposer must be capable of receiving TTY/TDD communications in accordance with Americans with Disabilities Act/Department of Justice Requirements.
5. Proposer will provide professional Emergency Medical Dispatch (EMD) with Medical Priority Dispatch System (MPDS) protocols and pre-arrival instructions using International Academies of Emergency Dispatch (IAED) certified Emergency Medical Dispatchers.
6. Proposer will utilize accepted dispatch quality assurance programs and follow the compliance requirements of the IAED Accreditation Center of Excellence performance standards.
7. Propers shall utilize GIS software compatible with CAPCOG mapping data in order to expedite responses.
8. Proposer must use the most current map book for Johnson County as published by Johnson County GIS and Addressing Department.
9. Separate dispatch and field operations supervisors (Off Truck) will be on duty at all times, 24/7/365, and will be jointly responsible for posting assignments and other adjustments to field assignments.
10. A.C. E accreditation is not required, but as outlined in this section, the Proposer shall describe how these desired conditions will be accomplished, including any exceptions or additions proposed and the requirement is that the proposer will follow the compliance requirements of the IAED Accreditation Center of Excellence performance Standards (F, 6). The proposer must be able to describe how this requirement will be met.

CareFlite understands and accepts all the required criteria.

G. Cooperation with Other Agencies:

1. Maintain good working relationships with area law enforcement agencies, fire departments, medical first responders, medical air transport providers and other emergency services organizations. Enter into mutually beneficial support agreements with other ambulance providers.
2. Proposer shall provide standardized training with all medical first responder organizations with a focus on scene management and standard work process for first responders to support paramedics.
3. Proposer will work jointly with ESD on appropriate training requirements.
4. Proposer will develop response and scene policies and procedures (e.g., staging, fire support, and multi-patient) in collaboration with fire and law enforcement.

CareFlite understands and accepts all the required criteria.

H. Supplies:

Medical first responders maintain their own medical supplies. In the event a medical first responder uses medical supplies and materials on a patient to be transported by the MICU ambulance, the proposer shall provide a 1-for-1 replacement of the supplies at the time of patient hand off. The proposer is not required to restock first responders with supplies for materials used previous calls.

CareFlite understands and accepts all the required criteria.

I. Subscription Programs:

The proposer is allowed to establish and manage a subscription program in accordance with the rules and regulations of the Texas Department of State Health Services.

CareFlite has a well-established subscription program covering approximately 20, 895 members in Johnson County. Over the last 5 years, CareFlite's membership program has saved the residents of Hill and Kaufman Counties over \$4.1 million and \$2.8 million, respectively.

J. Published Charges:

The proposer may establish an ambulance charge fee schedule. The County Commissioners Court must approve the fee schedule annually. The proposer's fee schedule shall be posted on their website and publicly available for review and questions.

CareFlite understands and accepts all the required criteria. See Appendix 12

K. Customer Perception Survey:

The proposer shall have an ongoing patient experience/perception survey, to be approved by the County. Third party vendors are preferred but in-house processes may be considered. The survey may be distributed to all patients or a statistically significant sample each month. The proposers shall describe how they will accomplish customer surveying.

CareFlite understands and accepts all the required criteria.

L. Continuous Improvement Methodology:

The Proposer shall integrate a continuous quality improvement methodology (e.g., Institute for Healthcare Improvement Approach to Quality Improvement (IHI-QI), Lean, Six Sigma) for use by all staff to plan, improve, and control all aspects of the organization's performance. This should include the establishment of Key Performance Indicators that are monitored over time as a gauge of the system's overall level of performance to Johnson County. These should include at a minimum:

1. Clinical Indicators
2. Operation/Production Indicators
3. Medical Priority Dispatch
4. Financial Indicators
5. Workforce Indicators
6. Customer Satisfaction & Engagement Indicators
7. Safety & Risk Indicators

The Proposer should provide an explanation of its Continuous Quality Improvement methodology.

CareFlite understands and accepts all the required criteria. See Appendix 7 and Appendix 8.

M. Reporting and Review:

The following represents the desired conditions for Emergency Medical Service reporting. Proposer shall describe how these desired conditions will be accomplished, including any exceptions or additions proposed.

1. Proposer will provide scheduled and ad-hoc reports as requested by Johnson County to enable

Johnson County to comprehend status of Emergency Medical Service system and achievement of response time and performance standards.

2. Proposer will provide monthly operational reports containing data on call volume, calls outside of time parameters, late call cause analysis, requests for exceptions, mutual aid received, mutual aid given, unit hours, unit hour utilization, clinical care measures, number of air transports, including detailed justification & payer mix data.
3. Performance measures shall be reported monthly and displayed using run or Shewhart statistical process control charts.
4. Medical Priority Dispatch System (MPDS) compliance scores based on International Academy of Emergency Dispatch (IAED) minimum expectations for case evaluation and reported monthly.
5. Customer satisfaction metrics will be reported at least quarterly.
6. Financial reports and statements will be provided annually and as requested by Johnson County and include payer mix.
7. Johnson County shall be able to review Computer Aided Dispatch (CAD) data on a real-time basis and shall be provided a CAD data upload of individual case level data on a monthly basis.
8. Johnson County shall be able to request event specific data and reporting on an as needed basis.

CareFlite understands and accepts all the required criteria, unless providing the data violates the Health Insurance Portability and Accountability Act (HIPAA) See Appendix 8 for Clinical Quality Improvements.

N. Contract Monitoring:

The following represents the desired conditions for ongoing monitoring of Emergency Medical Service for quality, efficiency and contract compliance. Proposer shall describe how these desired conditions would be accomplished, including any exceptions or additions proposed.

1. Information shall be made available as described in this procurement and in the contract on a timely and accurate basis and as described above.
2. Information provided shall be consistent with dispatch logs, run reports and other data without prior edit or adulteration.
3. Information will be verifiable by Johnson County without undue or extensive effort.
4. Information will be accessible by Johnson County through the use of internet access, direct software connection(s) or other state of the art retrieval technologies.

CareFlite understands and accepts all the required criteria.

O. Ambulance Operations Requirements:

1. Coverage. The Proposer will provide emergency ambulance service for the entire County of

Johnson with the exception of the Cities of Burleson, Cleburne, Mansfield, and the Keene Fire District. The proposer will provide mutual aid to these cities and communities contiguous to Johnson County through State and County approved mutual aid agreements.

2. Response Time Requirements. Ambulances must be compliant with the following minimum response time requirements. Response times are a combination of dispatch operations and field operations. The Proposer shall be responsible for classifying all Emergency Medical Service calls using Medical Priority Dispatch System (MPDS) Protocols and using Emergency Medical Dispatch (EMD). Johnson County shall be involved in development and oversight of MPDS protocols. Johnson County does not plan to limit the Proposer's flexibility in the methods of deployment and providing service as long as the minimum response time requirements are achieved. ^{[[1]]}_{[[SEP]]} The Proposer shall place a transport capable MICU ambulance at the scene of all requests for emergency medical services within the designated response time at a minimum of a ninety percent (90%) rate for all emergency dispatch response requests. This rate will be measured monthly and reported to Johnson County.

A. Priority 1 - Life Threatening Emergency Responses (MPDS Echo, Delta)

Johnson county outside of the city limits of Cleburne-Proposer must arrive at the scene within 14:59 minutes at least 90% of the time and no response shall exceed 19:59 minutes.

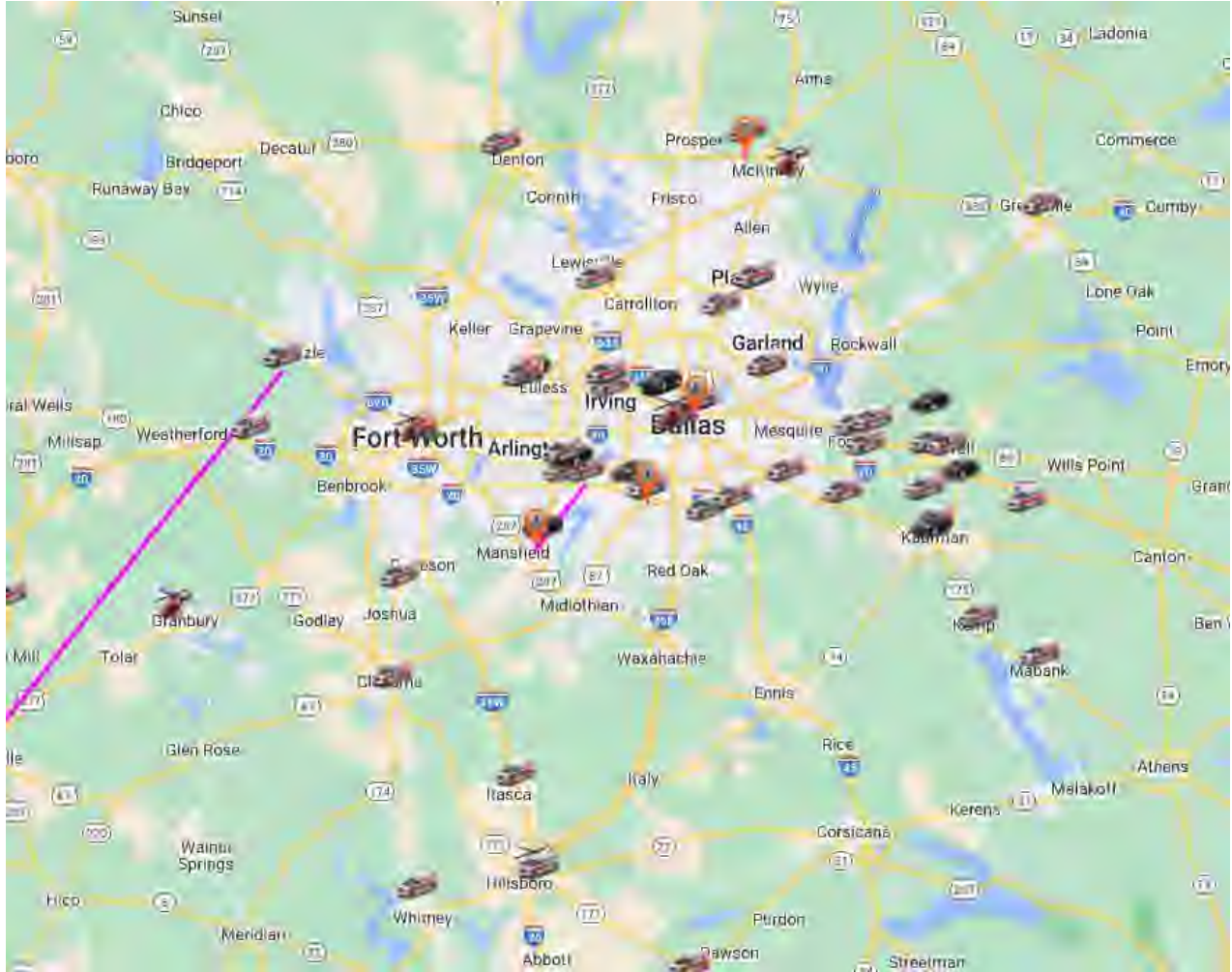
B. Priority 2 - Non-Life-Threatening Responses (MPDS Charlie, Bravo, Alpha, Omega)

Johnson County outside of the city limits of Cleburne-Proposer must arrive at the scene within 19:59 minutes at least 90% of the time and no response shall exceed 24:59.

C. Priority 3 Non-Emergency Responses (Alpha, Omega, no lights and siren)

Johnson County outside of the city limits of Cleburne-Proposer must arrive at the scene within 24:59 minutes at least 90% of the time and no response shall exceed 30:59 minutes

CareFlite continuously reviews historical data to evaluate the deployment of assets into areas of likely use. Logis utilizes artificial intelligence to provide continuous real-time data analysis dynamic, automatic resource-posting, improves response accuracy and manages resources more effectively. Using this data, we can save dispatchers 30 to 45 seconds per call to ensure arrival of the right resources to the right patient every time.



The proposer shall produce a report for the service interruption describing the situation of the event, background of the system leading up to the event, the assessment of the cause, and a recommendation for reducing or eliminating a similar event in the future. The report will be submitted to Johnson County with the monthly reporting.

d. Calculation of Response Times For all classifications of requests for service, the response time shall be the elapsed time (measured to the second) from the time “call received” to the time “arrival on scene”. The time “call received” shall be from the second the Proposer’s dispatch center is actually notified by the PSAP. The time “arrival on scene” shall be the time a fully equipped transport capable MICU ambulance arrives at the location of the patient or request for service and an ambulance crew notifies the dispatch center that it is fully stopped at the location where the ambulance crew will exit to approach the patient. First Responders and non- transport units do not constitute “arrival on scene” by

the Proposer.

e. Upgraded, Downgraded, and Reassignment Requests

From time-to-time, special circumstances may cause changes in call priority classification. Response time calculations for determination of compliance with contract standards will be as follows:

Upgrade: If an assignment is upgraded, prior to the arrival on scene of the MICU ambulance (e.g., from Priority 2 to Priority 1), the Proposer's compliance will be calculated based on the shorter of:

1. Time elapsed from call receipt to time of upgrade plus the higher priority response time standard, or
2. The lower priority response time standard.

f. Downgrades: If a caller or first responder on the scene reports information, which results in a downgrade of the dispatch classification from life threatening to non-life threatening, compliance will be calculated based on the priority 2 response time standard. If the downgrade requests occur after an ambulance has exceeded the priority 1 response standard, the priority 1 standard will apply. All downgrades will be reported in a monthly report including complete call details and downgrade justification. Johnson County has the right to accept or reject downgrade justifications.

g. Reassignment Enroute: If an ambulance is reassigned enroute or turned around, prior to arrival on the scene (e.g., to respond to a higher priority request), the Proposer's compliance will be calculated based on the response time standard applicable to the assigned priority of the initial response. The response time clock will not stop until the arrival of an ALS ambulance on the scene from which the ambulance was diverted.

h. Response Time Exemptions: The County understands that isolated instances may occur in which the Proposer does not meet the stated performance specifications. However, a chronic failure to comply with the response time requirements may constitute default of the contract. The Proposer shall maintain mechanisms for reserve production capacity to increase service production should a temporary system overload persist.

From time to time, unusual factors beyond the Proposer's reasonable control may affect the achievement of specified response time standards. These unusual factors are limited to those noted below.

1. Requests occurring during a period of unusually severe inclement weather conditions, unless weather was predicted sufficiently in advance that levels of preparedness should have been increased and such steps were not taken, when such response time compliance is either impossible or achievable only at a great risk to Emergency Medical Service personnel and the public.
2. In the event of Mass Casualty Incident, all ambulances responding to the Mass Casualty Incident other than the first ambulance on the scene.

3. Situations where the communications center receives false or inaccurate information or was unable to obtain adequate response information.
4. Requests during a declared disaster within Johnson County and confirmed by the County, in which the Proposer is rendering assistance. During such periods, the Proposer shall use best efforts to maintain primary coverage, while simultaneously providing disaster assistance as needed.
5. Request during times of unusually heavy call demand. Defined as call demand that is beyond the upper control limit of a c – chart (Shewhart Statistical Process Control Chart) derived from the most recent 20 weeks of call demand for the given time of day and day of the week.
6. In the event the ambulance response is delayed by a train blocking the roadway with no effectively alternative route, the ambulance will immediately communicate issue to dispatch. Response time will be paused until roadway is cleared and ambulance resumes travel.

Equipment failure, traffic congestion, ambulance failure, dispatch error, or other causes shall not be grounds for granting an exception to compliance with any response time standard. No other causes of late response time shall serve to justify exemption from response time requirements. However, the Proposer may appeal such instances to the County. Any appeals shall be filed with the County within ten (10) days of notification of the incident.

CareFlite understands and accepts all the required criteria.

P. Safety:

Emergency Medical Service provider and patient safety is important to the County. Proposers shall have policies and procedures to address evidence-based safety issues like injuries, motor vehicle crashes, and fatigue. Proposers should describe their approaches to ensuring safe practices including how shift schedule policies encourage adequate recovery.

CareFlite understands and accepts all the required criteria. CareFlite utilizes AngelTrax Mobile Video Surveillance. CareFlite utilizes Baldwin safety and compliance system to assess crew fatigue, report concerns, and mitigate risks. During onboarding, CareFlite trains employees on safe driving practices by teaching EVOS and Smith Driver Training. CareFlite is a part of the Association of Critical Care Transport, with employee representation on the board and education committee. CareFlite is also an active member of the North Texas Air Safety Council. CareFlite’s Director of Safety is a member of Every Coast Helicopter Operations (ECHO) organization.

Q. Transport Guidelines:

The Emergency Medical Service Medical Director in collaboration with the County will develop patient transport policies. Ground is the primary method for ambulance transport in Johnson County. Patients

will primarily be transported to the closest most appropriate emergency department. Ambulances may transport more than one patient in an ambulance when appropriate.

Air medical transport from a scene shall only be used when a patient meets objective clinical criteria for time sensitive transport and the travel time by ground exceeds the total cycle time from helicopter request/notification to patient arrival at the trauma center. Johnson County ESD Dispatch will request the closest, available air medical provider. The Emergency Medical Service Medical Director in collaboration with the County will develop patient air medical transport policies. Air medical transports will receive 100% review and be reported to the County each month.

CareFlite understands and accepts all the required criteria

R. Clinical Operations:

Johnson County wishes to provide evidence-based care reliably to the residents and visitors. Proposers shall describe how they will provide safe and reliable clinical care. CareFlite understands and accepts all the required criteria.

CareFlite understands and accepts all the required criteria. CareFlite has comprehensive protocols developed by our medical director and reviewed on an annual basis.

S. Emergency Medical Services Medical Director:

The proposer will contract with a practicing emergency medicine physician to provide Emergency Medical Service medical direction in adherence to the rules and regulations of the Texas Department of Health Services.

CareFlite understands and accepts all the required criteria.

Johnson County Emergency Services District and the Medical First Responder agencies all practice under the medical direction of a single Emergency Medical Service Medical Director. The proposer is invited to explore contracting with the County Emergency Medical Service Medical Director for uniform physician advising. If the proposer opts to not contract with the County Emergency Medical Service Medical Director, please explain how you will maintain continuous, local medical direction in partnership with the existing Emergency Medical Service Medical Director.

CareFlite opts to not contract with the Johnson County Emergency Medical Director.

CareFlite requests to continue our current Medical Direction through Dr. Robert Simonson. Dr. Robert Simonson has served as the CareFlite Medical Director services for 31 years. Cumulatively, Dr. Simonson has served as an Emergency Medical Director for over 39 years.

Dr. Simonson has committed himself to CareFlite as Medical Director for all of ground operations. He is dedicated to provide continued oversight of CareFlite and will maintain an open bi-directional relationship with the existing County Medical Director. Dr. Simonson will work closely with that individual to ensure high quality patient care for all citizens in the Johnson County region.

Dr. Simonson's responsibilities currently include writing and reviewing all protocols, oversight of physicians for on-line medical control and reviewing care provided by CareFlite clinical staff and attends monthly Clinical and Quality Improvement meeting. He routinely reviews clinical care provided by staff to ensure compliance with all Department State Health Services rules. Dr. Simonson is Board Certified in Emergency Medicine and is an integrated instructor of the National Association Emergency Medical Services Physicians Medical Directors Course. Dr. Simonson is on the State Medical Board and is compliant with all expectations of an Emergency Medical Services medical director.

1. The Emergency Medical Service Medical Director should provide medical oversight to ensure that the Proposer operates within the mainstream of the local healthcare system.
2. At a minimum the Emergency Medical Service Medical Director should have appropriate training, certification and licensure; expertise in Emergency Medical Service systems; and expertise in the specific type of operation. Ideally, the Medical Director should be a fully qualified member of the Proposers' operational Emergency Medical Service team. If the proposed Emergency Medical Service Medical Director has completed the National Association of Emergency Medical Service Physicians Medical Director Course, please provide the documentation. If he or she has not completed the program, he or she must complete the course in the next available offering.
3. The qualified medical director and his or her designees should ensure that a local standard of care is established and met. Such standards should coincide with all State of Texas statutes. This includes assuring that Emergency Medical Service personnel function within their defined scopes of practice, as established by their training and certification or licensure as outlined by Texas Department of Health Services.
4. It is the Proposer's responsibility to establish mutually agreed upon compensation for the services, availability and provision of necessary materials and resources, and liability coverage for duties and actions performed with the Emergency Medical Service Medical Director.
5. The qualified Medical Director shall ensure that the proposer's clinical operating guidelines and standards of care match or exceed the protocols for ALS providers in Johnson County.
6. Evidence-based Protocols and operating guidelines shall adhere to minimum requirements Texas Department of Health Services. In addition, protocols and guidelines should adhere to the guidance in peer-reviewed position statements by professional organizations including the National Association of Emergency Medical Service Physicians and the National Association of State Emergency Medical Service Officials and reports like

the Institute of Medicine’s Emergency Medical Service at the Crossroads and the National Highway Traffic Safety Administration Office of Emergency Medical Service sponsored consensus reports (e.g. Culture of Safety).

7. The Emergency Medical Services Medical Director shall establish an objective, clinically appropriate policy for ground and air medical transport decisions and for transport destinations.

CareFlite understands and accepts all the required criteria.

T. Clinical Training:

The Proposer should provide details on how the following clinical standards will be ensured.

1. All response personnel shall meet the minimal education and credentialing requirements as set forth by the Texas Department of Health Services in conjunction with the Emergency Medical Service Medical Director.
2. Emergency Medical Technician - Paramedics shall maintain current certifications in the following or acceptable equivalent:
 - a. Advanced Cardiac Life Support
 - b. Trauma life support certification such as:
 - i. Pre-hospital Trauma Life Support
 - ii. Basic Trauma Life Support
 - c. A pediatric emergency education program such as:
 - i. Pediatric Advanced Life Support
 - ii. Advanced Pediatric Life Support
3. Additional training in the following areas is desirable for all personnel:
 - a. Patient Safety
 - b. Multi-casualty / Disaster Response
 - c. Dealing with difficult patients
 - d. Infection control
 - e. Emergency vehicle driver operations
 - f. Medical/Trauma call management and paramedic assist (required for ambulance and first response)
4. The Proposer may require additional levels of training and qualifications.

CareFlite understands and accepts all the required criteria.

U. Clinical Leadership:

On the scene of medical call, in absence of the Emergency Medical Service Medical Director, the highest-ranking paramedic on the transporting MICU ambulance is responsible and the clinical leader of patient care. In the event of a rescue, fire, extrication, or law enforcement incident involving a patient, the clinical leader shall coordinate with the highest-ranking fire or law enforcement leader.

CareFlite understands and accepts all the required criteria.

V. Clinical Care Reliability:

The evidence-base for paramedic care is not robust. There is emerging consensus that paramedics may make a difference in several time sensitive conditions. While outcome data remains elusive, process data related to key processes for the core care pathways can be measured and improved. Proposers will track and report the following measures monthly and must achieve the performance standard within twelve (12) months of contract start.

There is little data sharing between First Responders and Emergency Medical Services unless it deals with direct patient care or contact. It is possible to get patient outcomes from Texas Health Resources facilities.

1. Deteriorating Patient
 - a. 90% of all adult patients receiving an early warning score assessment
 - b. 90% of patients with an early warning score of 4 or greater are transported within 10 min of MICU Ambulance arrival
 - c. 90% of patients with an early warning score of 4 or greater have early hospital notification
2. ST-Elevation Myocardial Infarction (STEMI)
 - a. 90% of patients with non-traumatic chest pain >35 years old, treated and transported by Emergency Medical Service who receive a pre-hospital 12 lead ECG
 - b. 90% of suspected STEMI patients transported to a STEMI Receiving Center, with pre-hospital call received at Emergency Medical Service PSAP to Device (PCI) < 90 Minutes
3. Stroke
 - a. 90% of suspected stroke patients receive an evidence-based stroke scale assessment (FAST, Cincinnati, LA Stroke scale)
 - b. 90% of suspected stroke patients receive a blood sugar assessment
 - c. 90% of patients arrive at the designated stroke center within three hours of symptom onset

4. Trauma

- a. 90% of trauma patients are assessed using the CDC Field triage Decision Scheme: The National Trauma Triage Tool
- b. 90% of patients with a positive vital sign/level of consciousness, anatomy of injury, or mechanism of injury are transported to a trauma center.
- c. 90% of non-entrapped patients with a positive vital sign/level of consciousness, anatomy of injury, or mechanism of injury should be transported within 10 min of MICU Ambulance arrival

5. Sudden Cardiac Arrest

- a. 90% of cardiac arrests identified by MPDS receive pre-arrival CPR instructions
- b. Reported only:
 - Percentage of out-of-hospital cardiac arrest receiving bystander CPR
 - Percentage of witnessed, out-of-hospital ventricular tachycardia/ventricular fibrillation cardiac arrest patients with return of spontaneous circulation at emergency department handover.
 - Percentage of witnessed, out-of-hospital ventricular tachycardia/ventricular fibrillation cardiac arrest patients discharged alive.

Clinical performance measures will be reported to the County on a monthly basis. Data will be reported in Shewhart statistical process control charts.

CareFlite understands and accepts all the required criteria.

W. Provisions for Default and Early Termination:

This procurement will result in the award of a performance contract requiring high levels of performance and reliability. Mere demonstration of effort, even diligent and well-intentioned effort, shall not substitute for performance results. Determination of default will be the responsibility of Johnson County Commissioners Court; however, an oversight committee may be appointed to monitor contract compliance, consider performance exceptions, consider other matters as assigned and make recommendations to Johnson County Commissioners Court. Proposer will be notified in writing if a default condition exists, and will be given 30 days to correct. Failure to correct the default condition will be considered a breach of contract subject to early termination of contract. Default conditions include, but are not limited to, the following.

1. Failure of the Proposer to operate the system in a manner consistent with Federal, State and Local laws, rules and regulations.

2. Intentionally supplying the County with false or misleading information with regard to records, documents, dates or time kept for the purpose of determining Proposer's performance under the terms of this proposal. Upon detection of accidental/unintentional error, the County shall be notified immediately and supplied with corrections.
3. Failure of the Proposer, its employees, its agents, or its representatives to conduct themselves in a professional and courteous manner and including professional appearance.
4. Failure of the Proposer to provide to the County data generated in the course of operations, including, but not limited to, patient report data, response time data, and financial data as specified in the contract.
5. Failure of the Proposer to assist the County in its takeover after the declaration of a breach of contract has been declared by Johnson County Commissioners Court.
6. Failure to substantially and consistently meet or exceed the various clinical standards provided for in the contract.
7. Failure of the Proposer to maintain equipment in accordance with manufacturer or industry maintenance practices.
8. Making an assignment for the benefit of creditors; filing a petition for bankruptcy; being adjudicated insolvent or bankrupt; petitioning by custodian, receiver or trustee for a substantial part of its property; or commencing any proceeding relating to it under the bankruptcy, reorganization arrangements, readjustment of debt, dissolution or liquidation law or statute.
9. Chronic failure of the Proposer to meet response time requirements as set forth in the contract. Chronic failure shall be defined as failure to meet the minimum response time requirements as noted in the contract for any part of the EOA for any two (2) of three (3) consecutive monthly reporting periods.
10. Chronic failure of the Proposer to meet any performance requirements of the contract. Unless where otherwise specifically indicated, chronic failure for this purpose shall be defined as failure to meet any performance requirement three times in a six-month period.
11. Failure to furnish key personnel of quality and experience.
12. Failure to submit scheduled or ad hoc reports, or other information.
13. Failure of the Proposer to maintain insurance requirements or provide timely notification of policy changes.
14. Any other failure of performance required in the contract which is determined to constitute an endangerment to public health and safety, or not be in the best interest of the County.
15. Failure to maintain any type of license, permit, or certification required by law in order to fulfill the requirements of the contract or in order to avoid fines and penalties imposed by law.
16. Persistent and repeated failures of Proposer to comply with any of the performance requirements may be considered a condition of default.

CareFlite understands and accepts all the required criteria.

IV. Competitive Criteria

Organizational Profile:

The organizational profile provides proposers to describe your organization, its key influences, capabilities, and how you operate in your competitive and evolving environment. This includes an organizational description describing your organization's key organizational characteristics and a summary of your organizational summary, which provides context of your organization's strategic situation. This is a required, but non-scored section.

CareFlite is a Texas, nonprofit 501(c) 3 corporation governed by a Board of Directors with representatives from our member facilities Texas Health Resources, Methodist Health System, Baylor Health Care System, Parkland Health and Hospital System, and the JPS Health Network. CareFlite and member facilities are nonprofit entities committed to high-quality patient care and community service. CareFlite is the only, fully integrated medical transport company serving North Texas to include both ground and air services. Since 1995, CareFlite has been accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS).

Established in 1979, CareFlite is the eighth oldest air medical transportation service in the nation, and the second oldest in Texas. In 1981, CareFlite began operating a Ground Ambulance Division in Dallas to support the helicopters and to provide non-emergency transportation to patients in area hospitals. CareFlite has bases in the following counties: Collin, Cooke, Dallas, Erath, Hill, Johnson, Kaufman, Parker, and Tarrant. CareFlite operates 911/Emergency Medical Services in Hill County, Kaufman County, and the City of Seagoville. CareFlite also provides back-up 911 response for the Cities of Cleburne and Burleson.

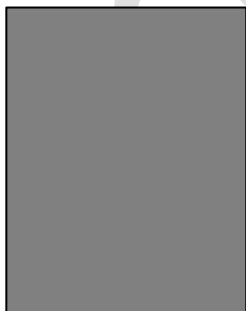
Today, CareFlite operates seven helicopter bases throughout the Dallas/Fort Worth Metroplex and Burnet County. The Bell 407 along with the Bell 429 aircraft are equipped for flight under instrument conditions (similar to the scheduled airlines). CareFlite has 12 FAA approved instrument approaches to area hospitals throughout North Texas. These approaches permit CareFlite to transport critical patients to the area's trauma centers and other hospitals offering specialized care during poor weather conditions. CareFlite is the first non-governmental entity to undertake such a program in Texas. CareFlite helicopters are based at Methodist Dallas Medical Center, Texas Health Harris Methodist Fort Worth Hospital, McKinney National Airport, North Texas Medical Center, Whitney, the Granbury Regional Airport, and Burnet. In addition to its helicopter Emergency Medical Service program, CareFlite also provides a King Air (fixed wing, twin engine, pressurized, high performance turboprop) air ambulance. This aircraft can be used for emergent transports in Texas and Oklahoma, long haul patient transfers throughout the continental U.S., and is ideal for transplant programs needing to move patients, organs for transplant teams without delay. Since its founding, CareFlite has transported over 1,255,000 patients by air and ground.

CareFlite also offers two Specialty Care Transport Mobile Intensive Care Units. Specialty Care Transport is an ideal service for a patient who needs an interfacility transport with a higher level of medical care than can be provided on an ALS ambulance but does not require the speed provided by flying. The specialty care provided include services such as ECMO, neonate, bariatric, ventilator, high-flow oxygen dependent, balloon pumps, advanced cardiac care and monitoring, and blood product administration. Specialty Care trucks are staffed at minimum by a Critical Care Paramedic and Emergency Medical Technician. These trucks are also staffed by a Flight Paramedic and Flight Nurse as needed on a case-by-case basis. CareFlite has an Infectious Disease Response Unit staffed by specially trained Paramedics and Emergency Medical Technicians that are equipped to transport EBOLA patients. CareFlite responds to requests from hospitals, fire departments, Emergency Medical Services agencies and law enforcement within a service area of more than 100 counties in a 150-mile radius of the Dallas/Fort Worth Metroplex containing more than 6 million people. Other services include an outstanding continuing education program that includes an annual continuing education conference which is open to first responders and all health care professionals. CareFlite is pleased to have the opportunity to respond to the Request for Proposal for Emergency Medical Ambulances.

Emergency Medical Service Medical Director

Dr. Robert Simonson provides CareFlite's Medical Direction. He is the chair of the Methodist Dallas Medical Center Department of Emergency Medicine, a member of the CareFlite Dallas Medical Advisory Board, and an Associate Professor with University of Texas Southwestern. He served for many years as Chair of the NCTTRAC Air Medical Committee and currently serves on the Texas Medical Board.

Dr. Simonson works collaboratively with CareFlite clinical staff and member agencies' leaders to ensure the Emergency Medical Service program administrative, operational, and clinical components are cohesive and complementary, while always remaining consistent with the mission, vision, and values set forth by CareFlite leadership.



Emergency Medical Service medical direction involves granting authorities to authorize and accept responsibility for the delivery of Emergency Medical Service patient care. Medical oversight ensures that competent medical professionals render care consistent with accepted standards. Medical oversight and direction are essential to all Emergency Medical Service systems as they help to ensure the appropriate delivery of emergency medical care to those with medical needs.

In Texas, Emergency Medical Service providers obtain certification or licensure through the Department of State Health Services (DSHS). However, this certification or licensure does not give permission for the individual Emergency Medical Service provider to function without being under the supervision of a licensed Emergency Medical Service agency and medical director. The medical director is responsible for ensuring the patient care activities performed by Emergency Medical Service providers are appropriate, within their scope of practice, and within operational expectations. This is accomplished through written clinical protocol and the provision of real-time consultation with Emergency Medical Services providers in the field, i.e., “Medical Control” via telephone or radio.

Medical Direction and Control encompasses many facets of an Emergency Medical Service agency in which a medical director should be engaged, including education and training activities, protocol and policy development, quality improvement activities, liaison, and corrective actions related to patient care actions by providers through:

- Protocols
- Standing Orders
- Online Medical Direction
- Offline Medical Direction
- Provider Credentialing
- Durable Medical Equipment, Supply, and Pharmaceutical Authorization
- Emergency Medical Service Continuing Education
- Quality Improvement & Performance Measurement
- Emergency Medical Service

Online Medical Direction is the management of patient care by physicians through contact with the Emergency Medical Service providers by radio, phone, or other communication devices. Emergency Medical Service providers may seek online medical direction consultation to obtain orders, perform a procedure, or administer a drug that is outside of standing written protocols. This communication allows for direct consultation on specific or unusual patient care situations and prepares the receiving facility for the incoming patient. Online medical control calls will be processed through the CareFlite Communications Center for linkage with physician medical control.

Offline Medical Direction involves the development, dissemination, and enforcement of written instruction. Through offline medical direction, the Emergency Medical Service provider acts as an agent of the

medical director. Offline medical direction includes the administrative promulgation and enforcement of accepted standards for out-of-hospital care, including protocols and standing orders.

Offline medical direction can be accomplished through both prospective and retrospective methods. Prospective methods include, but are not limited to, training, provider testing and certification, protocol development, operational policy and procedures development, and legislative activities [CareFlite Medical Director, Robert Simonson, sits on the Texas Board of Medical Examiners and is a strong advocate for Emergency Medical Services and pre-hospital care]. Retrospective activities include, but are not limited to, medical audit and review of care, process improvement and clinical quality management, direction of remedial education, and limitation of patient care functions.

Emergency Medical Service Provider Continuing Education Program Development: The medical director must be involved in the development and approval of all agency-based continuing education initiatives to ensure the accuracy and validity of the courses' medical content. To address individual areas of concerns or agency trends, the medical director should incorporate findings from the agency's clinical quality improvement initiatives into the continuing education program. There should be a seamless transition from the agency's quality efforts to its education programs. Continuing education should be designed to meet three main objectives:

1. Provide exposure to current trends and evidence-based advances in patient care.
2. Review areas of patient assessment and management that are not frequently used.
3. Meet certification or licensure renewal & transition requirements of the provider.

Quality Management: QI may be prospective, concurrent, or retrospective in nature. Emergency Medical Service providers and supervisors should be held accountable for the procedures that the medical director and agency leadership have put in place. Emergency Medical Service providers and other end users need to be involved in the process. QI activities should not be designed to be punitive in nature for individual providers but instead be focused on organizational improvements and conducted to educate providers and ultimately enhance patient care delivery. CareFlite conducts internal quality review of patient care on all 911 responses, all Advance Life Support responses (both 911 and interfacility), all critical care responses, and 10% of all interfacility Basic Life Support responses.

Performance Measures: Agency evaluation using performance measures can be imperative in the overall quality and effectiveness assessment of an Emergency Medical Service agency, particularly if the performance measure has been validated by peer-reviewed and evidence-based literature. A performance measure is a quantifiable criterion that relates to program quality. Internally, these indicators can be used as a quality evaluation and planning tool to determine and track agency activities as well as monitor efficacy of written protocol and standing orders. Externally, the indicators can be used as comparative and objective measures across different agencies [regional, state, and national]. An ideal measure is one that is not only quantifiable, but one that has been shown to make differences in

patient outcomes. It should be noted that a regional clinically relevant “best practices” approach should be used related to performance measures until true evidence is accumulated.

Emergency Medical Service Research Emergency Medical Services is in its relative infancy as an industry and as a method of delivering health-care services. Research activities in Emergency Medical Services are progressing, but have historically been recognized as one of the weaknesses in refining patient care and systems design in Emergency Medical Service. Several Emergency Medical Services research initiatives related to medications, equipment, Agency Oversight and treatment modalities are underway and have the potential to influence the Emergency Medical Services patient care delivery arena. CareFlite is partnering with LSU to pursue a whole blood initiative. Additionally, CareFlite is preparing to work the with Lites institute on a Ketamine pain study.

Medical Control

CareFlite provides medical control for all CareFlite Provider License Registered First Responder Organizations.

First Responders

Since 2007, CareFlite and the DFW Hospital Council have jointly sponsored the only region wide program honoring Great First Responders. Now the HEART awards, CareFlite recognizes outstanding area first responders each year at its Emergency Care Update Conference. Nominated by peers, the award recipients are chosen by CareFlite’s Advisory Council. This is a clear indication of our commitment to First Responders and the agencies they represent.

HEART award winners are unsung heroes who respond day and night, in all kinds of weather, to life threatening situations without hesitation or delay. A first responder can be a firefighter, an Emergency Medical Technician, a police officer, or a communications specialist in a first responder agency. They can be a paid professional in an urban department or a volunteer in a small, rural community. They all have a few things in common. They care about their fellow citizens and are willing to respond to all kinds of emergencies including some horrific situations. They are usually the first ones on the scene. They must make quick decisions, often in seconds, that can determine whether someone will survive a terrible accident. They must take care of the patient, protect the public and summon help. Sometimes at night. Sometimes awful weather. And sometimes alone. But even if they are alone, they are backed up by a team of people that are ready, on a moment’s notice, to bring additional resources. They assess your situation and proceed to give you as much aid and comfort as they can. These are First Responders. These are our community’s first line of defense against the tragic events that occur in our communities all too often.

HEART awards honor a group of first responders who are the best in North Texas. Unsung heroes. Unrecognized heroes. We honor them for:

- Going above and beyond the call of duty as a first responder.
- Commitment of the highest level of emergency care in the field.
- Demonstrating professionalism and setting the standard for your peers in life threatening situations.
- Putting service before self and making our communities better places to live.

We also recognize their families for the support and encouragement they offer the first responder in their family. A father, mother, a husband, a bother, a sister. Without the family support, these award winners and all first responders would find their mission difficult if not impossible.

Education and Training of Clinical Personal

CareFlite is well known for providing Emergency Medical Service education and has provided Emergency Care Attendant classes throughout Hill, Bosque, and Kaufman counties. Annually, CareFlite offers a two-day Emergency Care Update Conference with the latest clinical and safety offerings. Hosted since 1982, CareFlite’s conference offers continuing education classes delivered by prominent local and national educators.

CareFlite dedicated the state-of-the-art Mabee Emergency Medical Service Training Center in Grand Prairie in 2012. Many personnel from numerous local ambulance services and hospitals come to CareFlite for training. The Mabee Emergency Medical Service Training Center has 5 patient simulators. Individual rooms have been specifically outfitted to accommodate the specialized training. CareFlite offers an initial Emergency Medical Technician course that provides employment to non-certified individuals. These academy recruits feed into the CareFlite ground system after passing the National Registry Exam at the conclusion of their course. CareFlite’s pass rate for both their Emergency Medical Responder and Emergency Medical Technician courses surpass national average pass rates. (See Chart Below for Statistics) CareFlite recently purchased a 66,000 square foot facility in Irving that will house a new training center complete with hospital, air, and ground simulation capabilities.

Level	CareFlite Program				State				All Programs			
	Passing		Below Passing		Passing		Below Passing		Passing		Below Passing	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent

EMR	24	89%	3	11%	821	66%	424	34%	12,031	73%	4,467	27%
EMT	103	95%	5	5%	12,230	76%	3,919	24%	151,388	79%	39,976	21%

Dispatch Center Operations

The CareFlite Communications Center is the only center in the area that has been awarded the National Academy of Emergency Dispatch designation under ACE and uses state of the art technologies and the latest in deployment strategies to anticipate the current and future needs of our customers. The Communication Center Director and Quality Assurance Manager hold CareFlite’s IAED Recertification, just received, for the next three years. (See Appendix 6) Measurable standards are monitored daily, weekly and monthly in order to ensure courteous service, prompt and efficient mobilization of resources, and appropriate initiation of care through the use of Emergency Medical Dispatch protocols on every 911 call. The tables below illustrate examples of these standards.

CareFlite uses the Medical Priority Dispatch™ system and specifically the PRO QUALITY ASSURANCE computer model to prioritize calls, provide pre-arrival instructions and dispatch life support to all emergency medical related calls. By using a priority system, CareFlite ensures that the best asset available is sent to the call, and the proper response level is chosen minimizing liability, and maximizing the effectiveness of the system and its assets. These measures translate to better response times, more satisfied patients and family members, improved safety for responders and lowers system costs.

Computer Aided Dispatch:

CareFlite uses Logis IDS as our Computer Aided Dispatch under VLI Technology as our vendor. Logis IDS is a unique product as it is specifically designed for the Emergency Medical Service industry. Through the use of Logis, CareFlite’s Communication Specialists have real time information on the location of all the companies’ assets via the Automated Vehicle Location (AVL) system and the benefit of field enabled status updates through the Logis IDS mobile application.

CareFlite utilizes a software from VLI Technology called Vanguard EMERGENCY MEDICAL SERVICE Anyware, which gives CareFlite partners access to information such as CareFlite vehicles within assigned areas, county levels, and call information. Dispatch centers and fire departments can be given access to Vanguard upon request.

Staff and Training

Our current staff is comprised of 28 Communications Specialists who are EMD (Emergency Medical Dispatch) certified, 4 full time supervisors, a full time Manager, and a full time Director who is also certified as an EMD-Q and Certified Flight Controller. Several Communications Specialists are also certified as Emergency Medical Technicians and Paramedics who actively participate in field operations.

Newly hired employees are required to complete approximately 12 - 16 weeks of competency-based training in areas such as customer service, medical terminology, Emergency Medical Service operations, policies & procedures, telephony and CAD operations, deployment strategies, EMD certification, flight following procedures and basic flight dispatching. An additional 10-12 weeks of training is required to obtain certification as a Certified Flight Communicator (CFC) and function as a full flight dispatcher.

Completion of continuing education is required monthly and topics are based on Emergency Medical Dispatch curriculum and areas of improvement identified by performance indicators. A wide variety of additional training opportunities are available to employees outside of mandatory CE's.

Communication Center Management

CareFlite's Communications Center is managed by a Director, Manager and Shift Supervisors. Workflow is designed for maximum efficiency and 911 calls are answered by Emergency Medical Dispatch Trained personnel only so as not to delay call triage or pre arrival instructions. Our current protocols are designed by Medical Priority Dispatch Inc. and are designed to be most effective with personnel who are not certified or medically trained. As previously mentioned CareFlite uses a sophisticated Computer Aided Dispatch system and associated software applications to provide a high level of service.

CareFlite recognizes the importance of allocating the proper resource the first time and spends much time and effort monitoring customer service and compliance standards. Over 15% of emergency calls are reviewed through the use of EMD-Q for compliance to protocols and driving education and feedback to employees for improvement. This center also is responsible for reporting data to field operations regarding volumes and response time reliability as well as reporting departmental compliance to Key Performance Indicators.

Communications Center performance is reported daily, weekly and monthly to the management group for discussion and participates in company Quality Management and Safety Committee processes. The Communications Center is managed to a level required by the National Academy of Emergency Medical Dispatchers and we have recertified our center as a "Center of Excellence" (ACE) in quality patient care.

These standards must be met 90% of the time or better:

Call Type	Dispatched	Crew Acknowledges	Unit Responding	Response Time Standard
911 (Priority 1-3)	:59	:30	:59	Specific to priority/contract
Ground Interfacility:				
Emergency EIFT	1:59	:30	4:59	30 min or < from call
Urgent	1:59	:30	4:59	90 min or < from call
Non-Urgent	Negotiated	:30	4:50	Scheduled time +/- 15 min
Air Response				
Rotor Scene	:59	:30	VFR 8 min	ETA +/- 1:59 (2)
Rotor Interfacility	:59	:30	VFR 8 min	ETA +/- 1:59 (2)
Fixed Wing:				
Scheduled	n/a	:30	Scheduled	ETA +/- 29:59
Emergent	:59	:30	29:59:00	ETA +/- 29:59

Monthly Reporting

CareFlite is accustomed to meeting response time requirements and is very successful in meeting demand because of the strict attention paid to performance. Response time compliance is measured and

reported daily, weekly and monthly. Reports are completely customizable which means there are nearly endless formats available for data and information is readily accessible at all times

A. Organizational Environment:

1) Emergency Medical Service Offerings:

For greater than 44 years, CareFlite has been providing Emergency Medical Services and support to first responder agencies. From 2003 to 2017, CareFlite had the privilege of serving as Johnson County's primary 911/Emergency Medical Service. The coverage area for which CareFlite served was roughly 734 square miles with a population of approximately 167,000 citizens.

Johnson County CareFlite Emergency Medical Services will include:

- 24-hour Paramedic Supervisor Oversight
- 7 Mobile Intensive Care Unit (M.I.C.U.) Ambulances
- 1 Operations Manager
- 1 Associate Operations Manager

As part of CareFlite's responsibility to the Johnson County community, we provided emergency ground ambulance transports, transport of patients from the hospital as well as transport of residents from long term nursing facilities. This was done consistently without diminishing our abilities to exceed compliance expectations when responding to emergency calls. While this expectation was an agreement-based performance metrics; the CareFlite leadership and team believed this was their responsibility to the community.

Our organization holistically is well respected and appreciated across the Dallas Fort Worth Region. Our mere scope of influence allows us to provide continuous improvement initiatives to better serve our ever-growing community.

Process improvement initiatives, transparency with performance metrics and involvement of community members within the CareFlite organization will continue to prove that our services within the community are highly valued.

Historical performance metrics and patient satisfaction indicators accurately depict CareFlite's future and ongoing performance. The following performance metrics provide a descriptive affirmation solidifying the expectation of our organization in meeting the need of the patients and communities we serve.

2) Mission, Vision, Values:

MISSION

To bring help and hope to the communities we serve by providing unequalled and compassionate care.

VISION

Building a highly competent, resilient, and resourceful team that puts the needs of others ahead of their own to save more lives.

OUR CORE VALUES

One Team, Incomparable Quality, Safety Culture, Unequaled Integrity, Caring Hearts

CareFlite's organization core competencies and expectations of all team members are quality assurance, customer service, innovation, and continuous professional development. These competencies are the backbone on which our mission, vision and values are built. These activities and initiatives instill and continuously reinforce how CareFlite brings help and hope to the communities we serve.

3) Workforce Profile:

CareFlite has approximately 450 ground team members in the DFW Metroplex and surrounding communities. The organization's oversight is directed in collaboration with a Board of Directors from dedicated sponsoring facilities including: Texas Health Resources, Methodist Health Systems, Baylor Scott and White Healthcare System, JPS Health Network, and Parkland.

CareFlite's core values, dedication in career advancement and longevity as evidenced by our years of service to the community provide a concrete foundation for retaining quality, high performing team members. The people that encompass our team are the strength of our organization and as such, we devote tremendous resources to provide a safe, comfortable work environment ensuring that our employees are focused on what they do best, patient care. CareFlite's staffing challenges mirror that of Emergency Medical Services throughout the nation. CareFlite has, within recent years, implemented two initiatives to drive recruitment and advancement. First is the aforementioned initial Emergency Medical Technician program and the second is a CareFlite sponsored cohort of students enrolled in the University of Texas at Dallas paramedic program. Both serve to attract and keep talented and qualified individuals as a part of the CareFlite team.

To promote employee satisfaction and support the needs of our team, CareFlite as an organization strongly encourages work-life balance. To help promote the healthy behaviors of our team, CareFlite encourages that team member's use 80 hours of paid time off annually. CareFlite, additionally, has an organizational wellness program. CareFlite's wellness initiative is a multi-faceted program that includes many different avenues for participation to include but not limited to wellness screenings, healthy living programs, and employee assistance programs.

CareFlite, as a healthcare organization, requires initial physical ability testing as a hiring screening tool to ensure our employees are fit for duty and to avoid injury. CareFlite also participates in programs

provided by the American Heart Association, and National Association of Emergency Medical Technicians.

Educational Requirements include:

- Completion of a policy/procedure review such as CareFlite's company structure, mission, vision, values, Employee handbook policies, Health Insurance Portability and Accountability Act, billing compliance, harassment, infection control, managing stress, conflict resolution, communicating effectively, protocols, navigation, system design and resources, clinical quality, operational quality
- Complete all annual required training including Hazardous materials, National Incident Management 100, 200, 700, 800 (as applicable), and Fire Safety
- Three weeks of classroom training including patient handling, Blood Borne Pathogens, driver's training, documentation class, equipment and protocol training, hands-on scenario training with Human Patient Simulation and defensive driving.
- Required card courses to include Advanced Cardiac Life Support (as applicable to certification level), Pre-Hospital Trauma Life Support, Basic Life Support, Pediatric Advanced Life Support (as applicable to certification level), and, Neonate Resuscitation Program (as applicable to certification level).
- Field Training Officer training (release is competency based as demonstrated by proficiency with protocols, equipment, skills, operations)
- Protocol testing with a minimum passing score of 80

Field Training/ Evaluations:

Emergency Medical Technician basic field training and evaluation consists of approximately 160-200 hours of objective based training conducted by a Field Training Officer. Emergency Medical Technician paramedic field training and evaluation consists of approximately 240-320 hours of objective based training conducted by a Field Training Officer. Once objectives are met and by the Field Training Officer's recommendation and all performance documentation is reviewed by CareFlite's Education Coordinator verifying satisfactory completion.

CareFlite Ground does not have any bargaining unit or unions.

CareFlite has a Designated Infection Control Officer, and required physical ability testing. To ensure consistent and high-quality screening, CareFlite contracts with third party Occumed for all pre-employment fitness testing. For safety, CareFlite has chosen to purchase Horton ambulances due to numerous enhanced features such as: patient compartment 4-point retractable harness seat-belts, seat-belt airbags, enhanced shock absorption in patient compartment seating, and air bag equipped action wall. Additionally, CareFlite is in the process of completing installation of Stryker Power Pro 2 auto-load systems in all ground units. To further enhance safety, CareFlite utilizes AngelTrax in vehicle mobile surveillance systems which allows real-time monitoring of driver behavior and policy adherence.

CareFlite employees are encouraged to monitor activity levels and, per policy, utilize a Baldwin risk assessment when fatigue may place them in an unsafe state.

4) Assets:

Grand Prairie Hanger and Mabee Training Center, Northern Corporate location and training center, simulation mannequins adult, pediatric, and obstetric, simulation training ambulance, AngelTrax, Zoll cardiac monitoring, Lifeline ARM chest compression device, i-view video laryngoscopy devices, Stryker Power Pro 2 auto-load system, Hamilton ventilators, Baxter Spectrum IQ Infusion System, Type I ambulances (Frazer and Horton), Type II ambulances (Sprinter, Transit), Type III ambulances (AEV, Horton, Crestline), Specialty Units (ECMO, Bariatric, Balloon-Pump, and Neonatal capable), and Supervisor response Tahoe.

5) Regulatory Requirements:

CareFlite participates in associations/accrediting bodies such as the Commission on Accreditation of Medical Transport systems. Best practice implementation occurs through attending local, state and national conferences and meetings with Regional Advisory Committees in North Central Texas, Heart of Texas, and Texas Capital Area for clinical operating guidelines.

B. Organizational Relationships:

1) Organizational Structure

CareFlite's organizational and governance systems are relatively linear. Leadership and management structures utilizing this methodology support organizational transparency that allows us as an organization to respond to opportunities timely. This focus on transparency promotes employee engagement in process improvement initiatives, ultimately allowing CareFlite to delivery high quality patient care continuously. The CareFlite team and informal leadership have direct access to all senior leadership to include open and welcomed dialogue with all levels of senior leadership to include the CEO. This structure not only promotes bi-directional communication to meet the needs of the organization as well as the patients we serve but also maintains administrative costs.

Reporting structure and communication expectation with governance boards, and keys stakeholders takes place through CareFlite's Board of Directors.

2) Patients, Other Customers, Stakeholders:

At CareFlite all patients encountered, family members, fire department personnel, hospital staff and our Board of Directors are our customer and stakeholders. We pride ourselves at CareFlite in the

deployment of highly trained individuals, professionalism and innovative patient care. (see Appendix 13)

3) Suppliers and Partners:

Key suppliers and partners that support the need of CareFlite include Baylor Scott and White, Texas

Health Resources, John Peter Smith, Parkland and Methodist Health Systems. These stakeholders are vital to success of the delivery of CareFlite that provides. Due to the intensive nature of our services; it is the expectation that services are rendered timely. Customer service of these key suppliers and partners are imperative to the safe delivery of care.

To enhance the competitiveness of CareFlite, we strive to utilize the newest most evidenced based products. CareFlite utilizes AngelTrax, Lifeline ARM chest compression device, i-view video laryngoscopy devices, Stryker Power Pro 2 auto-load system, Hamilton ventilators, Baxter Spectrum IQ Infusion System, and Type I ambulances (Frazer and Horton) to ensure delivery of quality care.

Key supply chain requirements include having local and national vendors to replenish stock in a timely manner or when an emergency occurs.

Related to the organizational maintenance of ambulances, CareFlite has full time Fleet Maintenance Management team dedicated solely to ground operations. All ambulance vehicles are inspected on a daily basis. Daily inspections include: all fluid levels, tires, brakes, safety features, adequacy of lighting and visual damage assessment. Support Services personnel, Field Supervisors or Managers, complete weekly inspections. These inspections provide a more comprehensive assessment of the aforementioned items and also additional items such as shocks, suspension, belts, tire wear patterns, batteries, etc. CareFlite has adopted a specific weekly vehicle checklist provided by our insurer, VFIS Inc. Multiple vendors perform preventative maintenance and repairs. These designated vendors are required to complete documentation of specific items each time a vehicle is seen. Vendors are required to submit evidence of insurance with a minimum of \$1,000,000.00 liability coverage. Main Street Elite, Kris Brown Chevrolet and Cleburne Ford currently provide maintenance services for our fleet of vehicles in the Johnson and Hill County areas. Preventative maintenance is performed according to OEM standards or better and parts wear is tracked through the use of an in-house database to determine replacement intervals prior to failure. This database in conjunction with daily inspections has proven to be the most effective way to ensure our transport vehicles are in pristine condition.

Vehicles are scheduled for replacement every 5 years or 300,000 miles. Vehicles over 200,00 miles are predominantly used as “reserve” ambulances and not front-line vehicles. Mileage and maintenance costs

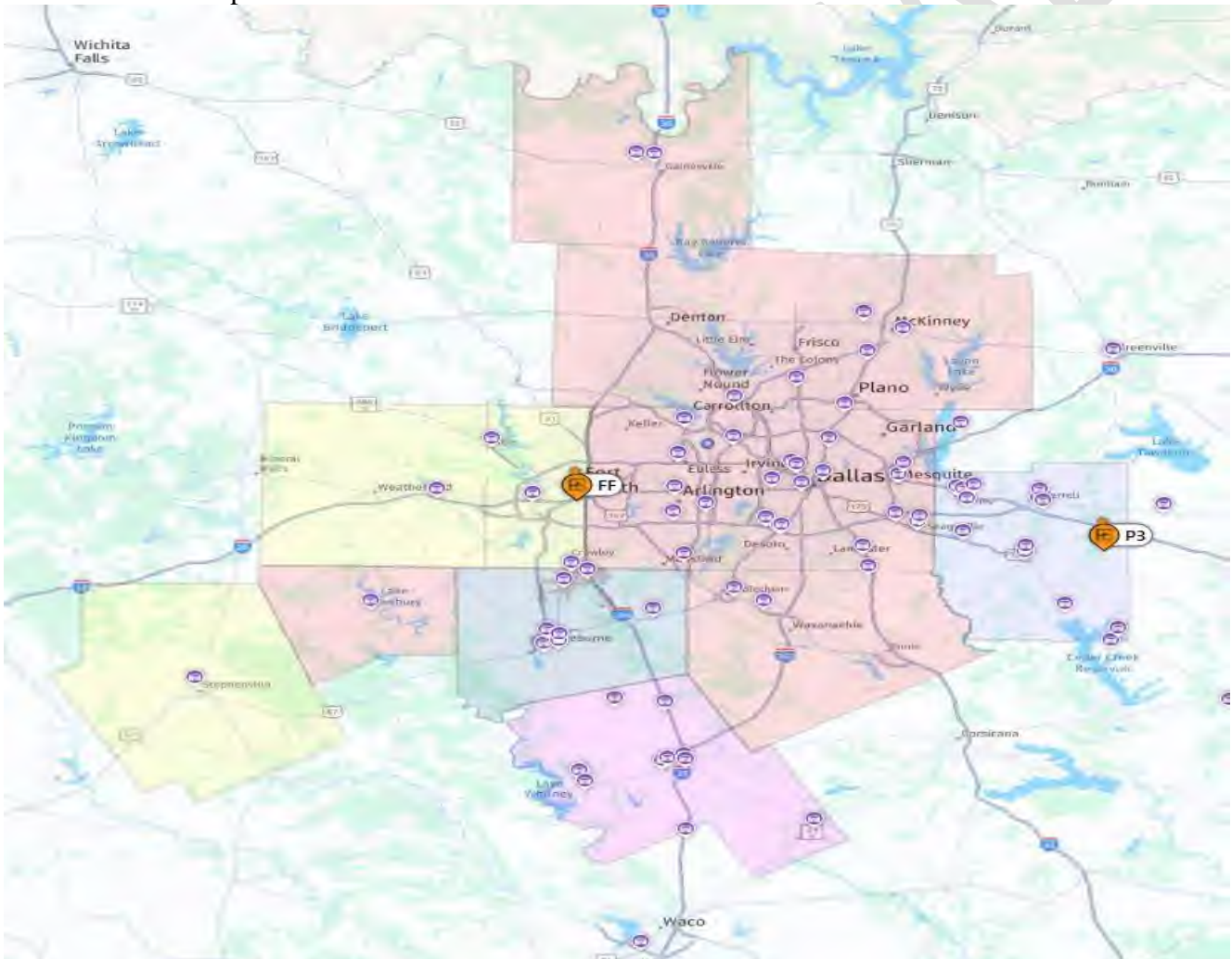
are not the only determinants of vehicle fitness. Critical failures and out of service time are also considered.

Organizational Situation:

A. Competitive Environment:

1) Competitive Position:

CareFlite Ground Operation Area



Helicopter Emergency Medical Services Operations Area



CareFlite has a large geographical footprint across Dallas/Fort Worth and surrounding areas. CareFlite additionally provides air medical transport in Burnet, Texas and immediate surrounding areas. The CareFlite organization has over 650 total employees that span from direct caregivers; which include Emergency Medical Technicians, Paramedics, Registered Nurses and an array of ancillary support staff. The CareFlite organization values the importance of all CareFlite team members as they all support the same organizational mission and vision. Our organizational size is considered to be a high-capacity Emergency Medical Service system as comparable to other organizations.

CareFlite as an organization provides complete modalities for emergency transportation. We continuously look for opportunities to expand our services to better support the needs of our community. This is evidenced by a multitude of designated CareFlite ground ambulance stations as well as our dedication to providing air transportation in strategically placed locations across of span of service to provide prompt transport as requested by the communities we serve.

CareFlite has a reputation in the community for being trustworthy and setting the highest standards of emergency medical services in the area while staying committed to the overall health of the community. Due to the longevity of our services, CareFlite is a brand name amongst many community members.

CareFlite leads the Emergency Medical Services competition as an organization that values innovation and providing high quality patient care to all they serve.

Key competitors include American Medical Response, Acadian, Allegiance, and City Ambulance.

Key collaborators include but are not limited to our member facilities; Texas Health Resources, Methodist Health System, Baylor Health Care System, Parkland Health and Hospital System, and the John Peter Smith Health Network.

2) Competitive Changes:

To overcome and surpass competitive situations, CareFlite creates opportunities for expansion and allows for innovation to propel the organization forward through growth of the ground and air service districts.

Strategic advantages include multidisciplinary organization. Some other strategic advantages that CareFlite employs are early mentoring practices and team building through coaching and professional development.

3) Comparative Data:

Key sources utilized by the CareFlite organization for comparative and competitive data include consultants for audits clinically, financially and operationally. CareFlite values the importance of quality improvement and continuous improvement initiatives to guide the services we provide. The utilization of both statistical and quantitative data from both within emergency medicine and through the analysis of other success business we continue to grow as an organization.

B. Strategic Context:

Strategic advantages and initiatives in emergency medical services (EMS) can greatly enhance the effectiveness and efficiency of response, ultimately leading to improved patient outcomes. CareFlite utilizes the following:

Integrated Communication Systems: Implementing advanced communication systems that allow seamless coordination between EMERGENCY MEDICAL SERVICE providers, hospitals, and other first responders significantly reduce response times and ensure appropriate resource allocation.

Community Engagement and Education: Developing community outreach programs to educate the public about basic first aid, CPR, and when to call for emergency assistance can help reduce the burden on CareFlite and First Responder Organizations by empowering individuals to handle minor emergencies and recognize when professional help is needed.

Data-Driven Decision Making: Utilizing data analytics and predictive modeling to identify trends, hotspots, and high-risk populations can enable CareFlite to allocate resources more effectively, optimize deployment strategies, and proactively address emerging health concerns.

Training and Continuous Professional Development: Investing in ongoing training and professional development programs for CareFlite personnel ensures that they stay abreast of the latest medical advancements, protocols, and techniques, enhancing their ability to deliver high-quality care in diverse emergency situations.

Collaboration with Other Healthcare Providers: Building strong partnerships with hospitals and first responder organizations can facilitate seamless transitions of care, enhance information sharing, and promote a patient-driven approach.

Resource Optimization and Efficiency: Employing strategies such as dynamic deployment models and unit-based triage can help optimize resource utilization, reduce ambulance turnaround times, and minimize response delays during peak demand periods.

Disaster Preparedness and Resilience: Developing comprehensive disaster response plans, conducting regular drills and simulations, and establishing mutual aid agreements with neighboring jurisdictions enhance the ability of CareFlite to effectively manage large-scale emergencies and ensure continuity of care under challenging circumstances.

Quality Improvement and Performance Measurement: Implementing robust quality assurance and performance improvement programs allows CareFlite to monitor key performance indicators, identify areas for improvement, and benchmark their performance against national standards, ultimately driving continuous quality enhancement.

By strategically focusing on these initiatives, CareFlite not only enhances its operational efficiency and effectiveness but also plays a pivotal role in improving public health outcomes and strengthening community resilience.

CareFlite's key strategic challenges include the continuous growth of the non-profit organization of air and ground to the communities of North Texas.

The advantages of the organization's strategic plan in regard to Emergency Medical Services include maximizing quality assurance, customer service, innovation, and continuous professional development.

Operational advantages at CareFlite include the ability to adjust to the changes in the healthcare environment, driven by the Patient Protection and Affordable Care Act, and other statutory, regulatory and economic changes. The responsibility of CareFlite in regard to the community is a key focus in the organization's strategic plan. Workforce advantages include using multiple employees not only part of

the CareFlite family but also residents in Johnson County. Monthly hiring of employees typically is restrained to county residents if applicable.

C. Performance Improvement Systems:

Elements of CareFlite's strategic plan in relation to performance improvement systems successfully providing customer service excellence, by giving the patient and the county the best quality of care at the lowest possible price due to being non for profit.

Our current process improvement initiatives are evaluating triggers that assist in the response times, compliance, patient focus and safety standards along with key performance indicators. As triggers are met, CareFlite aims to increase each point to the highest level of performance. CareFlite utilizes the A3 problem solving practice which is a dynamic way of thinking that organizes and synthesizes data in a clear and objective manner to achieve the established goal.

Summary of Competitive Criteria:

1) Leadership

1.1 Senior Leadership

a. Vision, Values, and Mission

1. Vision and Values - CareFlite senior leaders set the mission and vision of the organization through strategic planning processes. The strategic planning committee is composed of the Board of Directors, CareFlite's CEO, Vice-Presidents and Directors. Based upon the core values of CareFlite, the senior leadership in collaboration with frontline team members set a foundation and a standard of care under which we practice. The CareFlite senior leadership is committed to organizational sustainability through living out the defined mission, vision, and values in every facet of the organization.
2. Promoting Legal and Ethical Behavior - CareFlite senior leadership demonstrates their commitment to legal and ethical behavior through their actions by setting the tone at the top, establishing clear policies and procedures, providing adequate training and resources, promoting transparency and accountability, leading by ethical decision-making, complying with legal and regulatory requirements, addressing ethical concerns and misconduct, and encouraging ethical leadership throughout the organization.
3. Creating a Successful Organization - Senior leaders play a crucial role in ensuring that CareFlite is successful both in the present and in the future. The loyalty and investment of senior leadership to not only the patients we serve, but also the personnel that composes the entire CareFlite Team is the foundation of the organization. The cornerstone of a successful organization is its mission, vision

and values. This is reflected within the organization's strategic plan to sustain success and continue to exceed the expectations of the communities we serve.

b. Communication and Organizational Performance

1. The senior leaders of CareFlite communicate with the entire organization through multiple modalities. The senior leadership team utilizes weekly meetings with department directors who then hold routine meetings with staff to disseminate pertinent information to the teams. For information to a specific workforce group, senior leadership relies on leadership over that particular sector to disseminate. Senior leadership has constant bi-directional communication amongst all middle leadership within the organization assessing for appropriate utilization of resources. Senior leadership engages the entire CareFlite team through varied and innovative methods. Communicating with and engaging the entire workforce, as well as key customers and partners, is essential for CareFlite leadership to foster alignment, collaboration, and a sense of shared purpose.
2. Focus and Action - Action orientation is an essential behavior in a senior leader. CareFlite senior leaders serve as role models within the organization. They are committed to provide the organization with transformational guidance that supports the mission, vision and values of the organization. CareFlite's senior leadership contribute to immediate success and long-term viability through communication of strategic vision and direction, adaptability and innovation, talent development and succession planning, customer-centric focus, financial stability and resilience, ethical leadership, strategic partnerships, continuous learning and improvement, and long-term planning.

1.2 Governance and Societal Responsibilities

a. Organizational Governance

1. Governance System - The organizational governance system of CareFlite consists of senior leadership, internal and external corporate compliance. CareFlite ensures responsible governance by establishing structures, processes, and practices that promote transparency, accountability, integrity, and compliance with laws and regulations. This governance system is responsible for key aspects of the CareFlite organization to include accountability of organization, transparency of organizational performance, effectiveness of organizational processes, compliance of organizational expectations, and continuous assessment of the organizational strategic plan. This is done through an annual Strategic Planning Committee that is comprised of the CareFlite Board of Directors, Chief Executive Officer, Vice Presidents and Directors. The organizational governance structure meets CareFlite's Key Performance Indicators. The purpose of the organization structure is to fulfill societal responsibilities of CareFlite to the communities we serve.
2. Performance Evaluation - Evaluating the performance of senior leaders is crucial for ensuring effective leadership, driving organizational success, and fostering continuous improvement. One

way in which CareFlite evaluates senior leadership performance is through annual performance evaluations. Additionally, CareFlite utilizes an annual employee survey which allows for constructive improvement opportunities to facilitate continuous growth of leaders and ever-evolving healthcare environment. The performance improvement process is transparent and includes key actions to include establishment of clear expectations and objectives, definition of key competencies and behaviors, setting SMART goals, collecting feedback from multiple sources, assessing results and achievements, review of leadership behaviors and competencies, and consideration of stakeholder perspectives.

b. Legal and Ethical Behaviors

1. Legal, Regulatory, and Accreditation Compliance - CareFlite addresses concerns about our patient care and operations through employee surveys and corporate compliance. CareFlite plans to solicit direct customer feedback through satisfaction surveys completed by transported patients.
2. Ethical Behavior - CareFlite promotes and ensures ethical behavior through annual compliance training, open door policy and the ability to report any illegal or unethical behaviors through an anonymous compliance hotline that is answered and investigated through outside counsel. Additionally, through leadership modeling, CareFlite has established a code of conduct and provides leadership training, integrates ethics into performance evaluations, provides clear policies and guidelines, and regularly reviews and updates ethical policies.

c. Societal Responsibilities

1. Societal Wellbeing - CareFlite consistently goes beyond compliance orientation to meet the needs of the citizens in our current 911 districts. CareFlite intends to promote citizen well-being through community outreach and education programs, partnerships with local organizations, recognizing societal impacts on health, partnering in public health initiatives, and quality improvement data analysis. CareFlite is vested in the continued support and expansion of initiatives within the community.
2. Community Support - CareFlite will actively support and strengthen the Johnson County community through providing ambulance coverage at community events at no charge, attending Career Days at the schools who request our services, and participation in events such as Shattered Dreams. Additionally, CareFlite will provide medical resources beyond current conditions, improve response times, and deliver a quality of care that surpasses our competitors.

2) Strategic Planning

2.1 Strategy Development

a. Strategy Development Process

1. Strategic Planning Process - The CareFlite strategic planning process consists of at the least one annual meeting involving the Board of Directors, Chief Executive Officer and senior leadership. CareFlite's strategic planning is crucial in establishing clear goals, allocate resources effectively, and adapt to changing needs and priorities. Direction of strategic planning includes conducting situational and market analysis, review of adherence to mission, vision and values, setting strategic goals and objectives, developing strategies and action plans, monitoring and evaluating progress, and adapting and adjusting as needed.
2. Innovation - Essential to strategic development is an organization's ability to have focus on customer driven excellence, build operational capabilities, ensuring continuous assessment of organizational processes to propel improvement initiatives. CareFlite incorporates innovation into the strategy development process to stay competitive and adapt to changing market dynamics. At CareFlite, we encourage a culture of innovation and organizational transformation by consistent evaluation of current practices and strategizing avenues for change. This evaluation process allows for continual assessment of the environment and constant analysis for organizational sustainability.
3. Strategy Considerations - CareFlite's organizational data, with a focus on compliance, is analyzed on a daily, weekly, and monthly basis to identify trends and opportunities for improvement. CareFlite conducts a daily briefing to review staffing and consideration of resource allocation to best benefit the customers we serve. Additionally, CareFlite conducts review of and data collection for clinical practice guidelines and regularly reviews such with the medical director and clinical leadership. Follow up actions occur through weekly senior leadership meetings, unless immediate attention is required. Implementation of processes occurs through management staff and monthly crew staff meetings. The alignment between the organization and executives occurs by at least one annual strategic planning meeting. Alignment of key work systems and key work processes takes place through bi-weekly management meetings. Alignment of the work unit and job level occur through monthly supervisor meetings and daily interaction between field staff and supervisory team.
4. Work Systems and Core Competencies - CareFlite's key work systems are what enable us to provide unmatched quality in an effective and expeditious manner. CareFlite recently implemented a new computer aided dispatch system, Logis, which utilizes AI to improve effectiveness and efficiency. In order to maintain, track, and service our vehicles and equipment, CareFlite utilizes Manager Plus, an all-in-one asset management system. Additionally, CareFlite recently implemented a new charting software, Image Trend which allows for automatic and timely review of clinical performance as well as versatile data reporting utilized to improve overall patient care. CareFlite incorporates these key systems and their performance into strategic planning to ensure delivery of services in the most efficient way possible.

b. Strategic Objectives

1. Key Strategic Objectives - CareFlite strategic objectives stimulate and incorporate innovation through Key Performance Indicators which include: response compliance, time on task, out of service time, and alliance with (Ground and Air Medical Quality in Transport) GAMUT metrics. These performance measures are reviewed monthly to allow for dynamic, real-time modifications to processes and procedures that will drive the overall success of the organization.
2. Strategic Objective Considerations - Through constant organizational review of strategic initiatives, CareFlite ensures a balance and equity in competing internal needs first by allowing prioritization of objectives. CareFlite is also able to evaluate resources and allocation as well as mitigate risks and anticipate changes in industry landscape. This allows CareFlite to effectively manage and enhance all facets of the organization in a strategic way that satisfies the needs of all stakeholders.

2.2 Strategy Implementation

a. Action Plan Development and Deployment

1. Action Plans - CareFlite's action plan for both immediate execution and long-term cultivation and development is to increase the quality of patient care delivered to the citizens of Johnson County and increase efficiency through evaluation of response times. In the long-term, CareFlite plans to focus on continuous employee development contributing to employee satisfaction and retention.
2. Action Plan Implementation - CareFlite will increase the quality of patient care through on-going quality review of patient care documentation and the evaluation of data gathered as a result. CareFlite will utilize data to drive changes in patient treatment protocols and procedures. CareFlite will evaluate response data as a tool to recognize the need for and outcome of any alterations made to resource deployment and posting. CareFlite is committed to providing ongoing professional development in the form of internal education, sponsoring external education and training, and providing pathways for internal career advancement.
3. Resource Allocation - CareFlite is a non-profit organization with a key leadership structure that exemplifies attention to fiscal responsibility through its lean composition. CareFlite's Board of Director supported commitment to fiscal longevity is evidenced in its investment in quality equipment and fleet and asset replacement schedule. Through ongoing evaluation of current programs and practices, CareFlite will ensure the longevity of its action plans by employing a collaborative strategic planning approach. By engaging all stakeholders in the assessment and planning process, CareFlite gains a global evaluation perspective that allows for shared responsibility and accountability to the action plan success.

4. Workforce Plans - CareFlite has a clinical team dedicated to a focus on clinical guidelines that make us an industry leader in patient care. CareFlite's Director of Business Operations focuses on global response data and engages CareFlite's leadership team in the evaluation of that data and the development of improvement strategies. CareFlite's entire leadership team is engaged in the professional development of all staff and actively finds ways to mentor and grow others as a part of longevity strategies and succession planning. CareFlite's Emergency Medical Technician program ensures long-term recruitment and development to aid in sustaining CareFlite's qualified workforce.
5. Performance Measures - CareFlite will utilize its dispatch platform, Logis, to provide dynamic response and performance data for evaluation. Data from this system is available in real-time to the leadership team. CareFlite will use Image Trend, its charting software, to provide data for patient care quality metrics. Successful employee development will be measured through responses to employee surveys, analysis of employee tenure and turnover rates.
6. Performance Projects - CareFlite projects that it will meet or surpass response times as defined within the contract. Through continuous quality improvement efforts, CareFlite will succeed in improving patient care as evidenced by measurable achievements such as early hospital notification on 90% or better of patients with an early warning score of 4 or greater, 90% or better of patient with non-traumatic chest >35, receiving a pre-hospital 12-lead ECG, and 90% or better of suspected stroke patients receiving a pre-hospital blood sugar assessment, to name just a few. With ongoing professional development, CareFlite projects an increase in employee engagement and longevity as well as a decrease in turnover rate.

b. Action Plan Modification

As an emergency service company, we are very agile in accommodating short term crisis and will add resources necessary to continue to meet the requirements of our contract. CareFlite is poised to pivot as required in order to maintain focus on response compliance, patient care and employee development.

3) Customer Focus

CareFlite's goal is to provide the citizens it serves with a high-quality Emergency Medical Services System, where providers work together seamlessly to meet each other's and the customer's needs. To meet this goal CareFlite has a comprehensive internal continuous quality improvement plan in place.

3.1 Voice of the Customer - We will utilize customer surveys via phone call follow-up, postcards, and compliments/complaints by anonymous reporting to out sourced compliance services.

a) Listening to Patients and Other Customers

- 1) Current Patients and other Customers - CareFlite interacts with patients daily via transport. Any request or need is immediately addressed to achieve customer satisfaction. CareFlite will solicit the feedback of patients, customers and partners in care to evaluate performance and create action plans as needed. CareFlite performs ongoing review of patient care documentation, incoming 911 calls, and video monitoring data to evaluate performance and assess the need for change.
- 2) Potential Patients and other Customers - Another way to reach out to potential customers is through community outreach programs such as community cardiopulmonary resuscitation, public relations with school districts, routine encounters with hospital partners and collaboration with local fire departments in community development endeavors.

b. Determination of Patient and Customer Satisfaction and Engagement

- 1) Satisfaction, Dissatisfaction and Engagement - CareFlite has a policy and obligation to resolve any complaint or concern immediately and ensures resolution is achieved at the lowest level of management. (See Appendix 10) regardless of the source.
- 2) Satisfaction Relative to Competitors - Throughout the tenure in Johnson County, we consistently were present at county meetings, hospital meetings, and regional advisory council meetings in the area. All education that CareFlite hosts is open to all providers including competitors. CareFlite will initiate a customer satisfaction survey, distributed to transported patients, as an additional means of gathering patient feedback. We welcome feedback regardless of the source.

3.2 Customer Engagement - CareFlite has built its reputation with customers by being open, honest and transparent.

a. Service Offerings and Patient and Other Customer Support

- 1) Service Offerings - Service offerings are based off the needs and request of the community, first responders and surrounding facilities.
- 2) Patient and Other Customer Support - Patient support is offered through the supervisor that works 24-hour shifts, our dispatch center that operates 24 hours a day, the company website, and membership program.
- 3) Patient and Other Customer Segmentation - Customer groups and market segments are determined by populations that require prehospital healthcare and transportation. Additionally, CareFlite will

review call demand analysis to identify opportunities for change. CareFlite is open to consideration of additional service lines that benefit the community at large.

b. Patient and Other Customer Relationships-

- 1) Relationship Management - Relationships are built by involvement in our community, through community outreach and community education.
- 2) Complaint Management - CareFlite manages complaints by listening with an open mind to determine the root cause, effectively communicating throughout the leadership team and giving the patient a time and date, they should expect to receive a resolution. Once a resolution has been reached, CareFlite's practice is to be precise and honest, leaving no room for patient or customer negative perception aiming for customer satisfaction. (See Appendix ?)

4) Measurement, Analysis, and Knowledge Management

4.1 Measurements, Analysis, and Improvement of Organizational Performance – CareFlite measures and analyzes Key Performance Indicators: compliance reports, employee surveys, customer surveys, and Clinical Quality Improvement.

a. Performance Measurement

- 1) Performance Measures -The data will provide the information for best practices for the ongoing assessments and adjust annual Key Performance Indicators in the areas the company needs improvement. CareFlite data collection and evaluation allows for timely recognition of and response to customer needs.
- 2) Comparative Data - CareFlite would use a comparable service comparison from all organizations of similar size as indicated through North Central Texas and the Heart of Texas Trauma Regional Advisory Councils to build industry standards that CareFlite would incorporate to meet or exceed the standards. CareFlite will use state and national standards by which to benchmark success.
- 3) Patient and Other Customer Data – CareFlite would use patient and customer data to identify processes and results that represent best practices for patient care and performance. CareFlite will solicit feedback from partnering fire departments, hospital providers and community leaders to identify opportunities for improvement.
- 4) Measurement Agility – CareFlite has proven the ability to respond to rapid or unexpected internal or external changes by providing service to areas of the same size and population of Johnson County through collection of appropriate data, adaptation to short timelines and avoiding any measurable performance issues.

- b. Performance Analysis and Review – Performance reviews are measured by remaining in compliance with contract obligations and Key Performance Indicators.
- c. Performance Improvement
 - 1) Best Practices –CareFlite will share the data that details what has been successful and what pitfalls were discovered and adjusted to conform to contractual requirements.
 - 2) Future Performance – CareFlite projects future performance through analysis of current compliance trends, community growth, hospital system changes, and best practices.
 - 3) Continuous Improvement and Innovation -CareFlite will use the data from 4b to adjust posting assignments and/or system status management. CareFlite may also use this data to adjust deployment plans to meet or exceed contractual obligations, modify resources, and adjust patient treatment protocols.

4.2 Knowledge Management, Information, and Information technology- By effectively managing organizational knowledge assets, information, and IT infrastructure, CareFlite can enhance operational efficiency, support informed decision-making, and ultimately improve patient care outcomes.

a. Organizational Knowledge

- 1) Knowledge Management - CareFlite will manage organizational knowledge to ensure appropriate resources are allocated to the correct patient, in a timely manner. CareFlite has a commitment to transparency which facilitates information sharing amongst all stakeholders. This encourages individuals at all levels of the organization to participate in the dissemination of valuable information.
- 2) Organizational Learning - CareFlite will utilize the organizational values and missions through Just Culture processes which enable a learning environment conducive to change into a positive outcome. CareFlite utilizes a multi-faceted communication approach that allows for broad distribution of material across all personnel and learning types. CareFlite employs Ninth Brain, an online learning management system, patient care report software Image Trend, payroll platform ADP, monthly newsletters, employee staff meetings, onboarding, and in-person educational offerings to provide education, informational updates and training to all members of the CareFlite team.

b. Data, Information, and Information Technology

- 1) Data and Information Quality - CareFlite ensures the quality of data through established policies, protocols, and procedures.

- 2) Data and Information Security - CareFlite ensures the security of privileged information with the assistance of a Director of Corporate Compliance using standard operating guidelines and a robust identity and security access and authentication system. CareFlite's Information Technology department constantly evaluates industry trends in data protection and software encryption to ensure we meet or exceed standards.
 - 3) Data and Information Availability - CareFlite has a Custodian of Records and a Compliance Officer who address the limited availability and security of all protected data information.
 - 4) Hardware and Software Properties - CareFlite operates a fully functional Information Technology department that oversees all software updates and the continuation of service through maintenance and upkeep of pertinent equipment.
 - 5) Emergency Availability - CareFlite has a continuous Information Technology employee on call daily to address immediate hardware and software concerns. CareFlite provides access to triplicate paper resources to ensure completion of documentation during times of equipment failure. CareFlite's patient care documentation software constantly saves data to a storage cloud in order to complete documentation once failures have been mitigated. CareFlite currently has a location and plan to provide back-up communications support to ensure uninterrupted service. In addition, CareFlite is in the process of expanding its current dispatch capacity through the construction of a new center that will increase the level of capabilities and efficiencies of the current location.
- 5) Workforce Focus –
- 5.1 Workforce Environment– CareFlite has an open-door policy, and follows the core values set forth by the corporation.
- a. Workforce Capacity and Capability
 - 1) Capability and Capacity - CareFlite consistently evaluates its capacity and demand, adjusting its recruitment strategies accordingly.
 - 2) New Workforce members - CareFlite utilizes multiple employment website platforms to advertise current openings with details that include pay rates and benefits, including Indeed, Glassdoor, Monster, Careers Page, Zip Recruiter, and Link Up. CareFlite operates an internal Emergency Medical Technician program that provides a pathway for non-certified individuals to become certified and directly enter the workforce as a CareFlite employee. CareFlite holds hiring fairs, is active in the community at a variety of public relations events, and actively recruits graduates from local paramedic programs. The placement of new employees is determined by the open needs of the divisions. CareFlite offers a competitive wage and benefits packages, flexible schedule and opportunities to further their career goals with education.

- 3) Work Accomplishments - CareFlite manages the workforce through Just Culture, positive reinforcement and non-punitive clinical quality improvement. CareFlite organizes its internal reporting structure with a focus on span of control to ensure that appropriate oversight occurs at every level.
- 4) Workforce Change Management - CareFlite fosters an environment that encourages fellowship, community and belonging. This creates an engaging culture that leads to job satisfaction and long-term retention. CareFlite has a history of adding additional units/resources to meet the demands and growing needs of the community.

b. Workforce Climate

- 1) Workforce Environment - CareFlite has a comprehensive benefits package that includes numerous resources for mental health, wellness, financial health, and other health-centered benefits. CareFlite's insurance benefits offer discounted access to a "doctor on demand," which provides employees with affordable access to health care around the clock. CareFlite has partnerships with multiple fitness centers to offer membership at reduced rates in order to promote self-care and wellness. CareFlite's new Irving location will offer 24-hour access to an on-site fitness center and we are currently exploring potential for providing fitness equipment at ancillary bases.
- 2) Workforce Benefits and Policies - CareFlite utilizes Human Resources for employee benefits, updating policies, and offering additional benefits such as employee discounts, paid time off, paid time off cash out and the ability to use paid time off to offset the cost of benefits.

5.2 Workforce Engagement - CareFlite offers an annual performance evaluation that is directly linked to a merit increase. Senior management leads by example by projecting the expectations and ensuring the employees understand performance measures. CareFlite also conducts yearly employee satisfaction surveys to engage the workforce in affecting change within the organization.

a. Workforce engagement and performance

- 1) Organizational Culture - CareFlite has an open-door policy which ensures non punitive communication to increase morale which leads to a high performing engaged workforce. CareFlite employees are provided multiple avenues to report concerns either in person or anonymously. CareFlite employees are encouraged to openly share their ideas, accolades and concerns in an effort to improve overall quality of the organization and build a collaborative culture.
- 2) Drivers of Engagement - CareFlite determines key drivers of engagement through employee participation in the annual survey. CareFlite utilizes this employee listening strategy to identify key

challenges and opportunities to increase employee satisfaction. The feedback from this survey is crucial in helping CareFlite adapt to the needs of its workforce.

- 3) Assessment of Engagement - CareFlite assess workforce engagement by the willingness of our employees to offer staffing support, volunteer for nonpaid opportunities and volunteer to instruct or train new employees. CareFlite team member participation surpassed 75% in the 2023 engagement survey.
- 4) Performance Management - CareFlite employs multiple strategies aimed at supporting high performance and workforce engagement including clear performance expectations, continuous employee development and feedback, employee recognition program, encouragement of work-life balance and transparency. Through this comprehensive workforce management system CareFlite endeavors to enhance the quality of care given to the citizens we serve.

b. Workforce and Leader Development

- 1) Learning and Development Systems - CareFlite provides a supportive role for employees to grow within the organization. Each year since 1982 and free to employees, CareFlite hosts an Emergency Care Update Conference which provides clinically focused, industry-leading training for nurses, paramedics, emergency medical technicians and other first responders. In 2022, CareFlite hosted its inaugural Leadership Summit, offered to internal leadership team members, which focuses on leader resources, resiliency, safety culture, communication, and tools to build a stronger team. On personal development, CareFlite offers tuition reimbursement up to \$4500 per year for full time employees and \$1000 per year for part time employees. CareFlite offers, free to employees, ample educational courses within a four-year time span to meet the required number of hours needed for paramedic and emergency medical technician certification renewal as outlined by the Department of State Health Services.
- 2) Learning and Development Effectiveness - CareFlite measures learning and development success by achievement of clinical performance benchmarks, operational key performance indicators, safety metrics, and increased employee retention.
- 3) Career Progression - CareFlite will manage career progression through growth and leadership opportunities. CareFlite is a unique program that can offer many avenues for tenured employees. (For example- leadership roles, education roles, specialty care, communications and air medical) CareFlite offers professional development courses and sponsors employees to attend conferences that provide opportunities for growth. CareFlite takes an integrated approach to clinical management by partnering emergency medical technicians, ground paramedics, flight paramedics and nurses on practice committees which fosters collaborative learning. Additionally, CareFlite offers a mentorship program that creates a pathway for providers to learn from experienced peers in order to advance within the company.

6) Operations Focus

- 6.1 Work Processes - CareFlite offers many levels of service from Wheelchair van, 911 emergency ambulance service, non-emergent ambulance service, Specialty Care Transport, bariatric transport, rotor wing and fixed wing transports. Each of these transport modes requires a variably different work process. Each work process requirement pertains to the type of transport needed by the patient, but all work force requirements have a focus on one team, incomparable quality, safety culture, unequaled integrity, and caring hearts.
- a. Service and Process Design
 - 1) Service and Process Requirements - CareFlite determines key services and requirements dependent on contractual obligations, patient care requirements and patient/crew safety.
 - 2) Design Concepts - CareFlite will consider their suppliers, partners and contract requirements to carry out the overall design of work process.
 - b. Process Management
 - 1) Process Implementation - CareFlite designs its work processes around safe, urgent and quality delivery of patient care. By managing key factors CareFlite ensures a smooth work process with patients, vendors and collaborators alike.
 - 2) Patient Expectations and Preferences - CareFlite offers many modes of transport, and puts the patient's expectations and safety first and foremost. CareFlite will offer the most cost-effective appropriate transport to non-emergent patients, and will use the closest most appropriate destination for emergent patients. While CareFlite always tries to accommodate the patient's preference, the condition of the patient's health will be a factor in destination considerations.
 - 3) Support Processes - CareFlite will determine its key support processes based on contractual requirements. Additionally, CareFlite will seek opportunities for process improvement by analyzing various performance benchmarks from preventative maintenance to on-scene times and creating solutions to address identified gaps.
 - 4) Service and Process Improvement - CareFlite will use Quality Assurance and Quality Improvement practices as well as Key Performance Indicators to ensure consistent performance, adherence to our core competencies, and in turn these practices will reduce variability. CareFlite employs a root cause analysis approach in problem solving for identified barriers to success.
 - c. Innovation Management - CareFlite will manage innovations by being open to new products and services, weighing the outcomes on patient care and cost comparison. CareFlite employs

transformational leadership philosophies, encouraging its leaders and employees to routinely look for ways to innovate and push beyond industry standards.

- 6.2 Operational Effectiveness - CareFlite has a lean management structure to include a 24 hour on duty supervisor for each area of operations, an Associate Operations Manager and Operations Manager who may have oversight of multiple operations, and a Vice President responsible for the management and oversight of its entire ground operations. The on-duty supervisor is responsible for employees on his/her shift at the time and will answer any and all customer inquiries. The on-duty supervisor is responsible for getting resolution to any issues/inquiries that may occur during their shift, and will report the findings of any investigation to the Associate Operations Manager and Operations Manager. If, by chance the on-duty supervisor cannot get back to the customer with a resolution within his/her shift or less than 24 hours, the issue or inquiry must be passed on to the Operations Manager for resolution and he/she will contact the customer and assure customer is satisfied with the resolution, or given the information to pass the inquiry up the chain of command.
- a. Process Efficiency and Effectiveness - CareFlite uses an inventory control, asset management system and employee scheduling system to produce reports for medical supply usage, fleet and equipment out of service times, and unscheduled overtime. Using these reports, the Operations Manager will impose a work process to ensure any overages or oversights will be dealt with urgently to keep the operations within expense budget adherence.
 - b. Supply-Chain Management - CareFlite uses Manager Plus to manage daily medical supply usage and utilizes a multi-bid system to secure the highest quality and most cost-effective medical supplies. CareFlite manages inventory through monthly cycle-counts and ensures proper utilization of equipment by utilizing a service identification system. CareFlite utilizes a centralized purchasing model to ensure efficient ordering, a reduction in waste and bulk purchase pricing and maintains strong working partnership with its vendors. CareFlite employs a product standardization strategy to simplify inventory management and reduce supply costs. A most recent example of this is CareFlite's switch to a singular ambulance vendor in Horton, working toward a future organizational goal of uniformity of fleet.
 - c. Safety and Emergency Preparedness
 - 1) Safety - CareFlite utilizes AngelTrax Mobile Video Surveillance Solutions to ensure its employees operate all CareFlite vehicles in a safe manner. CareFlite's Director of Safety works closely with the Operations manager to ensure compliance with driving and patient handling standards and opportunities for crew education and improvement. There is also an area in the daily crew check sheet to report safety concerns to the on-duty supervisor who has the authority to make a decision on the removal of the ambulance from service until the safety issue is resolved.

- 2) Emergency Preparedness - CareFlite requires attendance to annual safety training and MCI drills for all field employees, supervisor and management. CareFlite has multiple medical supply warehouses throughout its operations areas to allow access to medical supplies that may be needed for an MCI, or declared disaster. (See Appendix 1)

7) Results

7.1 Health Care and Process Results - CareFlite is proud to be an industry leader in Emergency Medical Services. CareFlite's goal is to provide the citizens it serves with a high-quality Emergency Medical Service system where providers work together seamlessly to meet each customer's needs. To support this goal, CareFlite has a comprehensive internal Continuous Quality Improvement (CQI) program in place. Our goals align with the counties goals in wanting to:

- Improve and enhance Emergency Medical Service to internal and external customers
- Implement ongoing programs to evaluate the systems needs and changes
- Publish findings and changes using reports and study formats
- Monitor and evaluate the quality of our Emergency Medical Service using other tools, communication, and incident reports.

Constantly figuring out what customers want (both internal and external) and delivering it expeditiously is what creates growth and it requires speed and efficiency in just about everything we do. To accomplish this, we have adopted a 'Just Culture,' and use techniques that reflect the principles of a High-Reliability Organization [HRO]. Just Culture is an organized, coordinated, fair, multi-disciplinary approach, for investigating any internal or external customer concerns/satisfaction, personnel concerns, system issues, and clinical concerns, and improving patient care /outcome and services. This also allows us to identify areas of improvement, implement and evaluate changes that may be needed, and to promote serving ALL customers of Johnson County to the highest standards achievable.

Using the techniques and practices of a High Reliability Organization and using a Just Culture Program allows us to:

- Define the border between unacceptable behavior and honest error.
- Implement a non-punitive reporting and quality improvement system
- Embrace the concept of a "Learning Organization"
- Allows staff and management to communicate openly and often regarding safety.
- Allows our organization to have a deep commitment to analyzing and correcting mishaps
- Allows people at all levels to understand the hazards and risks of their operations
- Allows for a thorough investigative process with clear follow up and close the loop principles
- Identify strength and weaknesses through a Root Cause Analysis (RCA)
- Establish trend files
- Establish a self-reporting system to include "near misses" and provide a mechanism for feedback

- a. Emergency Medical Services Care and Customer-Focused Service Results - From 2003 to 2017, CareFlite averaged a 4.5 out of 5 customer satisfaction score over the previous 12-month period in Johnson County. CareFlite has gained loyalty to its customer base in Johnson County, which is proven in its 20,895 subscribers to the membership program.
- b. Work Process Effectiveness Results
 - 1) Process Effectiveness and Efficiency- CareFlite has consistently met or exceeded the contract compliance standards within each 911 district that we serve and have served. CareFlite is committed to evaluating its operations (posting plan, available resources, etc.) in order to make changes when necessary to support efficient and timely care.
 - 2) Emergency Preparedness - Recently (2022) we updated our Emergency Operations Plan. (Appendix 1) We have also ensured that all employees of CareFlite are compliant in NIMS 100, 200, 700 and 800 (as applicable).
- c. Supply Chain Results - CareFlite has reduced the number of critical equipment failures by implementing key mitigation strategies to include a robust preventative maintenance program and asset tracking. Additionally, CareFlite has made capital investments in industry leading, dependable and lasting equipment such as Horton ambulances, Hamilton ventilators, Lifeline ARM compression device, King Vision laryngoscopes, and Baxter IV pumps, to name a few.

7.2 Customer Focused Results - CareFlite's customer focus success is evidenced in CareFlite's customer satisfaction scores, successful response time compliance, industry leading reputation, and community presence.

a. Patient and Other Customer Focused Results

- 1) Patient and Other Customer Satisfaction - CareFlite will implement a feedback system to get customer satisfaction scores. All patients transported will be given a preaddressed and postmarked postcard to answer five questions about their care and service provided by CareFlite.
- 2) Patient and Other Customer Engagement - CareFlite utilizes a customer care email address for patients and the general public to engage with CareFlite leadership. CareFlite also participates in customer engagement through our social media outlets and provides transparent reporting with its direct customers and partners.

7.3 Workforce Focused Results- CareFlite's focus on workforce engagement and development is displayed by our workforce retention, compliance with training and certification requirements, and workforce wellness initiatives.

- a. Workforce - CareFlite has focused our results in many 911 entities that have shown to be successful.
- 1) Workforce Capability and Capacity - CareFlite has the capacity to operate multiple comparable 911 areas and the capacity to do so without placing a strain on current resources.
 - 2) Workforce Climate - Appendix 8 Confidential Employee Survey (Confidential Information Envelope) CareFlite offers a workforce climate that exhibits shared beliefs and values that contributes to the overall attitude and perceptions of its collective workforce. This environment is shaped through employee engagement, transparent and effective communication, positive team relationships, and opportunities for growth and development.
 - 3) Workforce Engagement - CareFlite finds positive ways to engage with and incentivize employees by implementation of a recognition platform, Awardco, an annual employee engagement survey, and EMERGENCY MEDICAL SERVICE Week celebratory activities. CareFlite's leadership engage their team members in quarterly conversations and maintain an open-door policy. Other routes for employees to participate in activities outside of their normal job duties include through CareFlite's clinical practice committee, staff meetings, as Field Training Officers or Station Leads and through the mentorship program. Consistently providing positive reinforcement and soliciting ancillary participation, cultivates an engaged workforce.
 - 4) Workforce Development - Successful workforce development is exhibited in several ways throughout CareFlite. First, as evidenced by employee survey results, CareFlite has a positive organizational culture that contributes to overall job satisfaction of its key stakeholders. CareFlite demonstrates exceptional organization performance in the volume of partnerships and customer bases that is it able to successfully maintain and cultivate. Additionally, CareFlite's clinical personnel provide superior patient care as evidenced in customer satisfaction, long-standing and continued partnership with key facilities, and a track record of successful patient outcomes. CareFlite has a peer support team that is made up of a group of employees who give their personnel time to provide assistance for members of their team who may be in need of emotional support; highlighting CareFlite's culture of adaptability and resilience.

7.4 Leadership and Governance Results - Effective leadership and governance contribute to overall organizational quality, sustainability, and delivery of high-quality emergency medical care through risk management, fiscal responsibility, leadership development, strategic planning, accountability, and transparency.

a. Leadership, Governance, and Societal Responsibility Results

- 1) Leadership - CareFlite has very little turnover in senior leadership of the company. Many key members of the senior leadership team have dedicated 15 to 20+ years of service to CareFlite and as

such, have developed a sense of trust and partnership within the company. The Chief Executive Officer leads by example and is highly engaged with the employees, provides regular, internal communication highlighting issues and successes within the company, has an open-door policy and sets a servant leadership example for other management to follow. Leadership has a duty to respond promptly including all good and bad. Chief Executive Officer is active in communicating in the organization's customers and patients. Management is empowered to make decisions in the best interests of CareFlite and the patient.

- 2) Governance - CareFlite is a 501 (c) 3 organization governed by a board of directors comprised of representatives of CareFlite's sponsoring hospitals. There are oversight committees including compliance, business practices, and human resources and as a result of the governance and leadership is the absence of government sanctions and lawsuits. CareFlite works closely with its legal team to ensure adherence to employment governance and regulations.
 - 3) Law, Regulation and Accreditation - CareFlite is accredited through the Commission on Accreditation of Medical Transport Systems, International Accreditation of Emergency Medical Dispatching, Accreditation as a "Center of Excellence", and highly respected by state and federal authorities. CareFlite holds itself to the highest standard.
 - 4) Ethics - CareFlite has policies and procedures many consider industry leading and for example, our social media policy has been cited in numerous national publications. CareFlite has a fulltime certified Compliance Officer, Custodian of Records and a very active compliance program. Everyone in the organization is held to the highest standard of ethical behavior. CareFlite maintains both internal and external reporting systems including a 24-hour hotline.
 - 5) Society - As a prehospital care provider, CareFlite plays a crucial role in supporting the communities it serves. We promote public awareness through outreach education, school career days, and events that promote health and wellness throughout the community. CareFlite partners with local fire departments and hospitals to participate in disaster management and preparedness exercises. CareFlite has a dedicated resource in its Director of Strategic Initiatives and Government Relations who advocates for initiatives that promote public health, improved access to emergency medical care and addresses issues impacting communities at large.
- b) Strategy Implementation Results-CareFlite measures its success in achieving organizational strategy and action plans through performance metrics and key performance indicators such as response time compliance, quality of patient care delivered and employee development and retention.

7.5 Financial and Market Results- See Appendix 3 and 4

a. Financial and Market Results

- 1) Financial Performance - CareFlite promotes a culture of fiscal responsibility in the acknowledgement that financial performance is crucial for organizational sustainability. CareFlite measures financial performance through revenue growth, financial stability, cost control and budget adherence, financial transparency and long-term fiduciary planning.
- 2) Marketplace Performance - CareFlite's marketplace performance is evidenced in its ability to meet the needs of the community, compete competitively in the market, and strategically and sustainably grow its operations. CareFlite judges marketplace performance by evaluating response times, customer satisfaction, service ability, market share and successful customer partnerships.

CONFIDENTIAL

- V. **Appendices**
- 1. Multiple Patient and Mass Casualty Guideline

CareFlite

Emergency Operations Plan

Emergency Medical Services

Ansel, Shane
8-5-2022

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NIMS ICS Forms

Common Terminology

The ability to communicate within ICS is absolutely critical. Using standard or common terminology is essential to ensuring efficient, clear communications. ICS requires the use of common terminology, including standard titles for facilities and positions within the organization.

Common terminology also includes the use of “clear text”—that is, communication without the use of agency-specific codes or jargon. In other words, use plain English. Executing the use of common terminology helps to mitigate confusion during multi-agency and multi-jurisdictional incidents.

This list of words and definitions are commonly used terminology as defined by NIMS.

After-Action Report (AAR): A document intended to capture observations of an exercise and make recommendations for post-exercise improvements. The final AAR and Improvement Plan (IP) are printed and distributed jointly as a single AAR/IP following an exercise.

Command: The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.

Command Staff: The staff who report directly to the Incident Commander, including the Public Information Officer, Safety Officer, Liaison Officer, and other positions as required. They may have an assistant or assistants, as needed.

Command Post: The central base of operations at the disaster scene.

Community Emergency Response Team (CERT): A community-level program administered by the Federal Emergency Management Agency that trains citizens to understand their responsibility in preparing for disaster. The program increases its members' ability to safely help themselves, their family, and their neighbors. Trained Community Emergency Response Team (CERT) volunteers provide immediate assistance to victims in their area, organize spontaneous volunteers who have not had the training, and collect disaster intelligence that will assist professional responders with prioritization and allocation of resources following a disaster.

Disaster: An occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in severe property damage, deaths, and/or multiple injuries.

Divisions: Refers to geographically defined areas, e.g., the area around a stadium, floors of a building, or sections of open ground.

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or by some combination thereof.

Emergency Operations Plan (EOP): An ongoing plan for responding to a wide variety of potential hazards. An EOP describes how people and property will be protected; details who is responsible for carrying out specific actions; identifies the personnel, equipment, facilities, supplies, and other resources available; and outlines how all actions will be coordinated.

Exercise: An instrument to train for, assess, practice, and improve performance in prevention, protection, response, and recovery capabilities in a risk-free environment.

FEMA: Federal Emergency Management Agency

Finance Section: Section responsible for tracking the related costs, personnel and equipment records, and administering procurement contracts.

General Staff: A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.

Groups: A functional unit with a specific goal such as triage, treatment, extrication, security, etc.

Hazardous Material (HAZMAT): Any substance or material that, when involved in an accident and released in sufficient quantities, poses a risk to people's health, safety, and/or property. These substances and materials include explosives, radioactive materials, flammable liquids or solids, combustible liquids or solids, poisons, oxidizers, toxins, and corrosive materials.

Hot Wash: A facilitated discussion held immediately following an exercise among exercise players from each functional area that is designed to capture feedback about any issues, concerns, or proposed improvements players may have about the exercise.

Incident: An occurrence, natural or human-caused, that requires a response to protect life or property.

Incident Action Plan (IAP): A document outlining the control objectives, operational period objectives, and response strategy defined by incident command during response planning.

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. The Incident Command System is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. ICS is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Commander (IC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and release of resources. The Incident Commander has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Incident Command Post (ICP): The field location where the primary functions are performed. The Incident Command Post may be co-located with the Incident Base or other incident facilities.

Incident Management: The broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity.

Incident Management Functions: Prevention, preparedness, mitigation, response, and recovery activities that occur in advance of an incident, during an incident, and/or following an incident.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, local boundary lines) or functional (e.g., law enforcement, public health, school).

Law Enforcement Group: Responsible for traffic control, overall security of the incident, and investigation if incident is caused by an unlawful act.

Liaison Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies or organizations assisting at an incident.

Local EOC: The EOC at the municipal or jurisdictional level. If none, the County EOC serves this function. Logistics Section Chief: Manages those units that provide personnel, apparatus, equipment, facilities and personal needs to support incident activities.

Logistics: The process and procedure for providing resources and other services to support incident management.

Logistics Section Chief: A member of the General Staff who provides resources and needed services to support the achievement of the incident objectives.

Medical Branch Director: Supervises the triage, treatment, and transportation groups.

Morgue Unit Leader: Establishes and maintains a temporary morgue designated by the Medical Operations Supervisor.

Multijurisdictional Incident: An incident requiring action from multiple agencies that each have jurisdiction to manage certain aspects of an incident. In the Incident Command System, these incidents are managed under Unified Command.

Mutual Aid: Agreements arranged prior to incidents that allow jurisdictions to work together to increase resources.

National Incident Management System (NIMS): A set of principles that provides a systematic, proactive approach guiding government agencies at all levels, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.

National Preparedness Guidelines (NPG): A document outlining the top priorities intended to synchronize pre-disaster planning, prevention, and mitigation activities throughout the Nation, and to guide Federal, State, and local spending on equipment, training, planning, and exercises. The Guidelines provide an overarching vision, tools, and priorities to shape national preparedness.

National Response Framework (NRF): A guide establishing a comprehensive, national, all-hazards approach to domestic incident response. It intends to capture specific authorities and best practices for managing incidents ranging from the serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters.

Natural Hazard: Hazard related to weather patterns and/or physical characteristics of an area. Often natural hazards occur repeatedly in the same geographical locations.

Officer: The Incident Command System title for a person responsible for one of the Command Staff positions of Safety, Liaison, and Public Information.

Operational Period: The period of time scheduled for execution of a given set of tactical actions as specified in the Incident Action Plan.

Operations Section: The Incident Command System (ICS) Section responsible for all tactical incident operations and implementation of the Incident Action Plan.

Operations Section Chief: A member of the General Staff who establishes the tactics to meet the incident objectives and directs all operational resources.

Planning Section: The Incident Command System Section responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the Incident Action Plan. This Section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Planning Section Chief: A member of the General Staff who supports the incident action planning process by tracking resources, collecting/analyzing information, and maintaining documentation.

Planning Team: A group of individuals with a variety of expertise and perspectives planning for all hazards.

Public Information Officer: A member of the Command Staff who serves as the conduit for information to internal and external stakeholders, including the media or other organizations seeking information directly from the incident or event.

Rescue Taskforce: Group responsible for locating and moving patients from a warm area to the triage and treatment area.

Resource Assembly Point (RAP): A pre-designated geographic location in the community, such as a store near a freeway exit, for outside resources to assemble for assignment to the community or incident.

Response: Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.

Safety Officer: A member of the Command Staff responsible for monitoring incident operations and advising the Incident Commander on all matters relating to operational safety, including the health and safety of emergency responder personnel.

Section: The Incident Command System organizational level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence/Investigations (if established)). The Section is organizationally situated between the Branch and the Incident Command.

Staging: A specific function where resources are assembled and managed in an area at or near the incident scene.

Staging Area: The location where incident personnel and equipment are assigned on an immediately available status.

Staging Area Manager: Position responsible for the check-in of all incoming resources; to dispatch resources at the request of command; and to request for additional resources to report to staging.

Standard Operating Guideline (SOG): A document with the aim of guiding decisions and criteria regarding management.

Standard Operating Procedure (SOP): An organizational directive that establishes a standard course of action from which there is no deviation.

State EOC: Is operated by the Division of Homeland Security, which is a division of the Department of Public Safety.

Strike Team: A combination of a designated number of the same kind and type of resources with common communications and a leader (i.e. EMS strike team).

Task Force: Any combination of single resources, but typically two to five, assembled to meet a specific tactical need.

Transfer of Command: The process of moving the responsibility for incident command from one Incident Commander to another. Transfer of command must include a transfer of command briefing, which may be oral, written, or a combination of both.

Transportation Group Supervisor: Coordinates the transportation of the injured to appropriate care facilities.

Treatment Group Supervisor: Provides coordination of medical care to injured.

Triage Group Supervisor: Coordinates sorting of casualties for treatment and transportation.

Unified Command: In incidents involving multiple jurisdictions, a single jurisdiction with multiagency involvement, or multiple jurisdictions with multiagency involvement, unified command allows agencies with different legal, geographic, and functional authorities and responsibilities to work together effectively without affecting individual agency authority, responsibility, or accountability.

Introduction

The purpose of the CareFlite Emergency Operations Plan (EOP) is to provide a systematic plan on the preparedness and execution of our incident management activities. Those activities include the response and recognition of an MPI or MCI, the mobilization of the ICS command structure, to efficiently triage, treat, and transport victims of both multiple patient incidents (MPIs) as well as multiple casualty incidents (MCIs). The goal of this plan is to identify, organize, triage, treat, and transport incident victims as efficiently and effectively as possible in order to minimize their morbidity and mortality. The components during an event may be expanded or contracted as necessary. This plan is designed to be an effective tool to be applied to any natural or man-made incident or disaster.

Core Objectives

1. To minimize the loss of life, disabling injuries, and human suffering by providing effective emergency medical assistance through the efficient utilization of medical and other resources in the event of emergencies resulting in multiple casualties.
2. To ensure the provision of adequate and integrated resources needed to mobilize teams to effectively manage casualties while also maintaining the capability and resources to respond to other emergency situations within the community.
3. The provision of assistance to the largest number of persons, through coordinated incident management principles. Based on the scope and nature of an incident, strict medical care principles may be implemented to serve the greater needs of the masses.
4. Establish a common organizational and management structure for the coordination of emergency response by multiple agencies to an MCI in CareFlites jurisdiction using the Incident Command System (ICS) which is structured by the National Preparedness Guidelines and National Response Framework.
5. A plan to effectively respond to and manage casualties of an MCI while maintaining capability and resources to respond to other emergencies within the county.
6. A plan for patient transportation/destination that maximizes the county hospital and trauma system addressing all modes of transportation.

Purpose

The purpose of CareFlites Emergency Operations Plan (EOP) is to establish the preparedness and response strategies related to natural and man-made emergencies and disasters. It outlines authority, responsibilities and organizational relationships, and shows how all actions will be coordinated within the agency as well as with external agencies such as Law Enforcement and the Fire Department.

Scope of Plan

This plan has been prepared to provide a coordinated response to the single site disaster that could overwhelm the day-to-day emergency health care delivery system. The MCI Plan is designed to supplement a countywide disaster plan.

Few, if any, government agencies have the resources to properly respond to major multiple casualty incidents. Law enforcement, fire, emergency medical services, hospitals, Red Cross and amateur radio operators are among the public and private agencies that become involved upon activation of the plan.

Jurisdiction and Command

Each agency shall retain full command authority within its jurisdiction at all times. Agencies that are assisting in support of a single jurisdiction will function under the direction of that jurisdiction's Incident Command and ICS for effective use of resources.

In multi-jurisdictional incidents, Incident Commanders will establish a Unified Command by planning and coordinating strategies for controlling resources and the overall incident at a single location Unified Command Post.

Texas Emergency Management Coordination

(From the Texas Department of Health Statewide EOP)

The following are basic concepts, sequences and procedures that drive preparedness and response in Texas. Note that the state and its jurisdictions rely on the National Incident Management System (NIMS) for planning, training, exercising for, and responding to emergencies and disasters.

In Texas, the initial response to emergencies and disasters is conducted by local jurisdictions working with city or county emergency management officials. A local government is expected to use its own resources and the resources available to it through mutual aid agreements before requesting assistance from the state. However, early communication and coordination is encouraged when additional resource needs can be anticipated.

If a jurisdiction's response resources are overwhelmed, imminently threatened, or a local jurisdiction is anticipating a resource need, the jurisdiction may request aid from its Disaster District Emergency Operations Center (DDEOC) (Tex. Adm. Code § 7.24). The DDEOC serves as a clearinghouse for local emergency response support from state agencies and entities. The DDEOC, when it is activated, is also the liaison between the local jurisdictions, Regional Emergency Operations Center (REOC), coordinates and supports operations among the impacted DDEOCs in the affected area, and the State Operations Center (SOC).

The SOC serves as a coordination and communications hub, allowing personnel to gather, evaluate and distribute critical information and resources and to respond to emergencies and disasters. Depending on the severity of the emergency or disaster, the readiness level of the SOC will range from a level IV Normal Conditions to level I Emergency Conditions, which requires the activation of additional components of the SOC and personnel to support operations. Appendix A outlines readiness guidelines for the SOC. Appendix B provides an example SOC organizational chart depicting the Texas incident command structure.

The state emergency management coordination system includes a number of key state decision-makers, which constitutes the Texas Emergency Management Council (TEMC). TEMC representatives are outlined in Executive Order GA 05. State law establishes, and executive order mandates the TEMC to advise and assist the governor in all matters relating to disaster mitigation, emergency preparedness, disaster response and recovery (Tex. Gov. Code § 418.013).

TEMC representatives have the authority to commit state or local resources necessary to meet prioritized needs and to request additional resources from other sources through the SOC. They also have the authority to issue mission assignments that involve the commitment of state or local personnel, material resources and funds to meet incident or disaster needs (Tex. Gov. Code § 418.013).

If the scope of the incident has expanded beyond the resource capabilities of the state, the SOC may seek intrastate mutual aid, assistance from voluntary and private sector organizations and/or federal aid as needed. In most cases, in order for the federal government to provide assistance, a federal disaster declaration is required. Federal assistance is not intended to fully compensate a

community for losses but to supplement available resources and prevent conditions from which the community could not reasonably recover.

Concepts of operations, state objectives and the responsibilities of state agencies relative to unique functional, support, or hazard specific activities are addressed in annexes to the State Plan. Appendix C identifies the objectives of each emergency support function (ESF) annex. Appendix D identifies the TEMC entities that play a lead or supporting role in response according to ESF.

*(Refer to the **State of Texas Emergency Management Plan** to reference the annexes listed in this section)*

Regional Advisory Councils

Regional Advisory Councils (RAC) serve to develop, implement and monitor regional emergency medical services (EMS) trauma system and to facilitate trauma system networking within and among Trauma Service Areas (TSA). Membership in a RAC may include hospitals, physicians, nurses, EMS providers, rehabilitation facilities, dispatchers and community groups. RAC's primary functions are to:

- Develop and implement a regional EMS/trauma system plan
- Provide public information and education about prevention of trauma and trauma systems
- Provide a forum for EMS providers and hospitals to address TSA issues
- Network with other RACs
- Document and report trauma system data

Local Disaster Declaration

The chief elected official of a jurisdiction may declare a local state of disaster for the following reasons:

- To exercise extraordinary powers.
- To activate preparedness, response and recovery aspects of any and all applicable local emergency management plans.
- To provide additional liability protection to government agencies and special or volunteer emergency workers.
- To formally request general assistance from the state and federal governments. According to Tex. Gov. Code Ch. 418, a declaration of local disaster may not be continued or renewed for a period of more than seven days except with the consent of the governing body of the political subdivision.

MCI Standard Response Levels Per NIMS Guidelines

LEVEL 1 (Type 5)

- Classified as an MPI
- Incident will require local resources and responding agencies. Incident may require additional resources within the region.
- Size – 5 to 10 patients
- Can be handled by one or two resources
- No IAP required
- Hospitals – notification to local hospitals in area near location of incident
- Triage – patients identified as RED, YELLOW, GREEN following START Triage guidelines and primary injury/service needed (May be able to direct patients to specific area emergency departments with appropriate resources in small scale event)
- Communications – primary: phone; secondary: radio

LEVEL 2 (Type 4)

- Incident will require local resources and responding agencies. Incident may require additional resources within the region.
- Size – 10 to 20 patients
- Command and General Staff activated only if needed
- No IAP required but documentation of the event is required
- Hospitals – notification to local hospitals in area near location of incident and/or adjacent city or parishes
- Triage – patients identified as RED, YELLOW, GREEN following START Triage guidelines and primary injury/service needed (LERN may be able to direct patients to specific area emergency departments with appropriate resources in small scale event)
- Communications – primary: phone; secondary: radio.

LEVEL 3 (Type 3)

- Incident will require multiple regional resources and responding agencies. Incident may require additional resources in adjacent regions.
- Size – 20 to 100 patients
- ICS positions should be filled to match the complexity of the event
- May extend into several operational periods
- IAP may be required for this type
- Hospitals – initial notification to all regional hospitals and/or adjacent regions

- Triage – patients identified as RED, YELLOW, GREEN following START Triage guidelines
- Communications – Phone and radio communications.

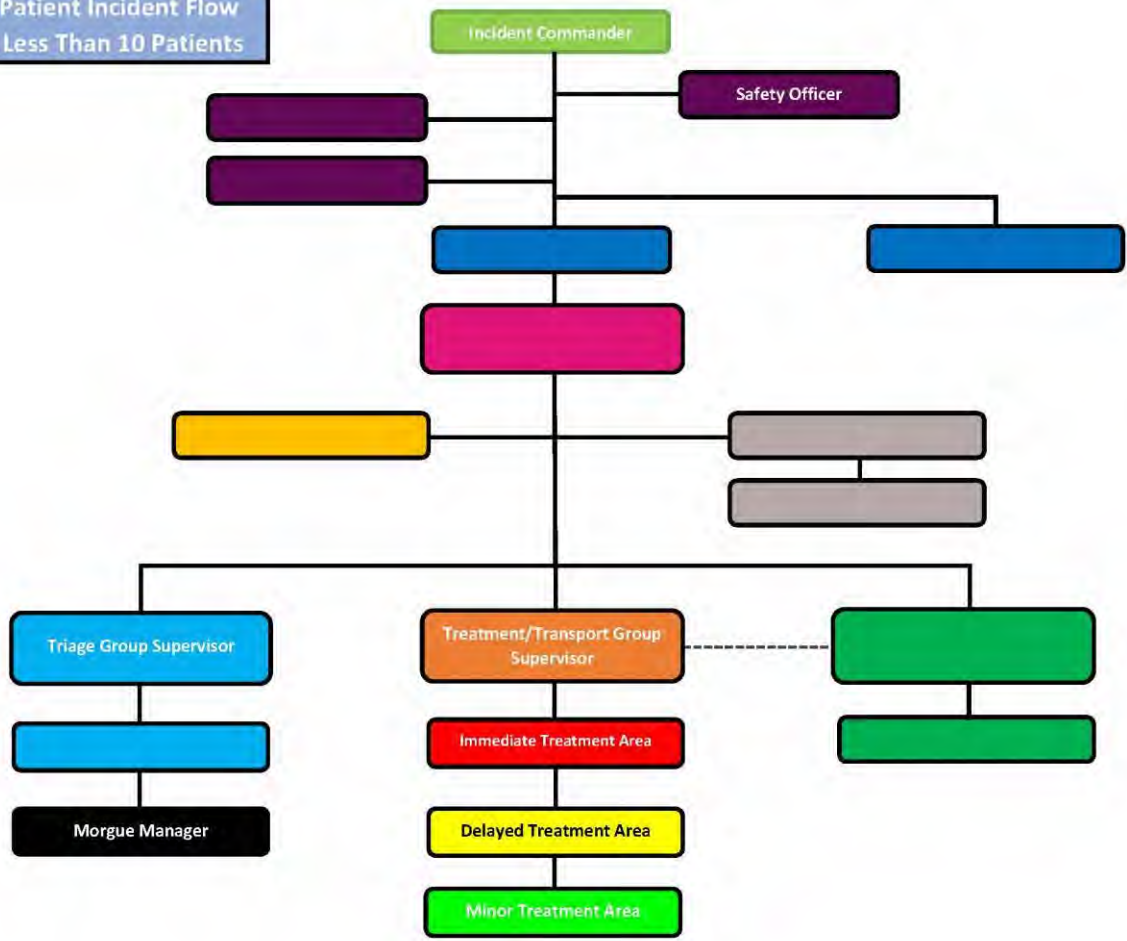
LEVEL 4 (Type 2)

- This event extends beyond the capabilities of local control
- Size – 100 to 1000 patients or casualties
- A written IAP required for each operational period
- All of the Command Staff positions are filled
- Operations personnel do not exceed 200 for each operational period
- Hospitals – initial notification to all hospitals statewide
- Triage – patients identified as RED, YELLOW, GREEN following START Triage guidelines
- Communications – Phone and radio communications. Incident command, operational officers, and the EOC will be in close communications

LEVEL 5 (Type 1)

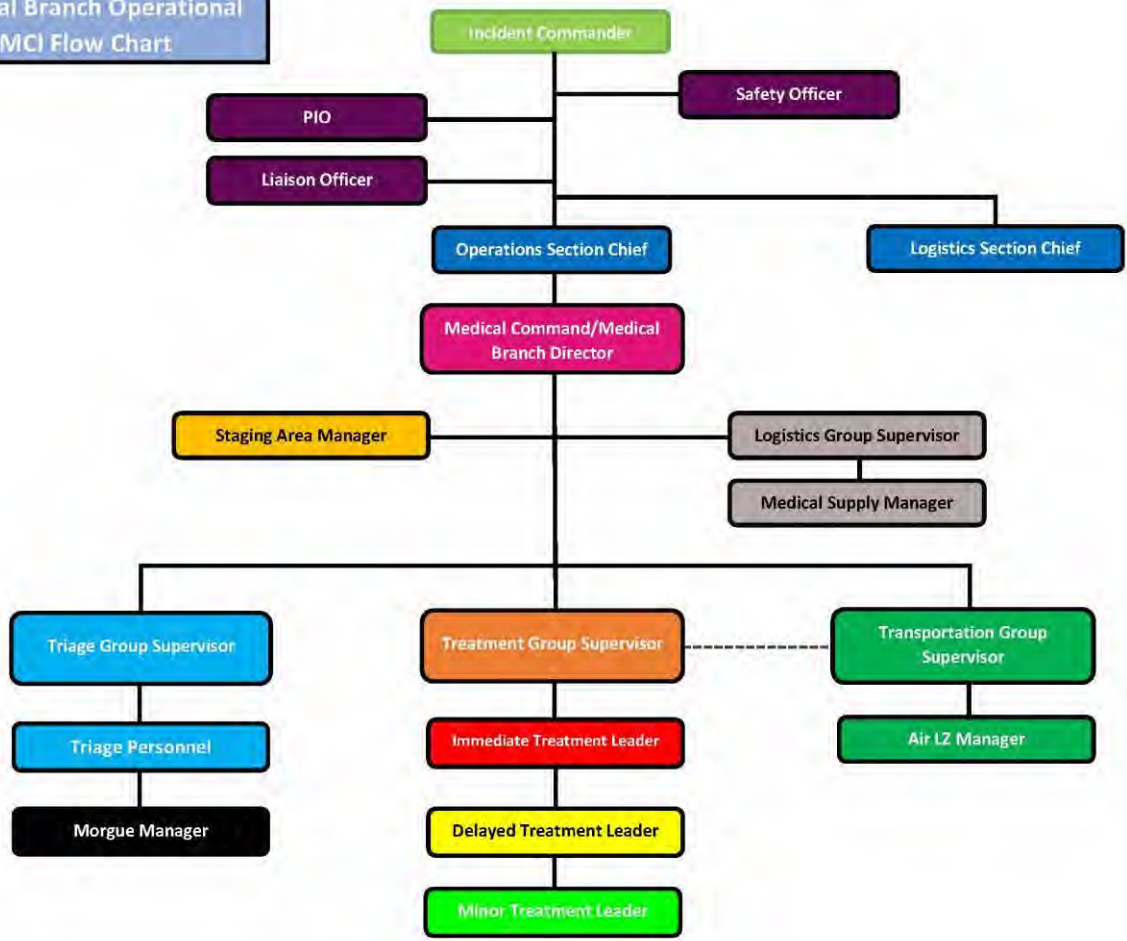
- The most complex situation
- Incident will require Statewide resources
- Size- over 1000 patients
- Operations personnel will exceed 500-1000 people per Operational Period
- Branches of the Command Structure will need to be established
- IAP will be required for each Operational Period
- Federal involvement
- Hospitals – initial notification to all hospitals statewide
- Triage – patients identified as RED, YELLOW, GREEN following START Triage guidelines
- Communications – Phone and radio communications. Incident command, operational officers, and the Joint EOC will be in close communication with each other

Multi Patient Incident Flow Chart: Less Than 10 Patients



CONFIDENTIAL

Medical Branch Operational
MCI Flow Chart



CONFIDENTIAL

General Organization Positions and Responsibilities

In determining staffing of each position, the IC must consider both the qualifications of the available personnel and the demands of the particular incident. Positions should be staffed based on the best use of available resources. **Position check sheets are located after this section.**

Use of Position Titles

ICS positions have distinct titles.

- Only the Incident Commander is called Commander—and there is only one Incident Commander per incident.
- Only the heads of Sections are called Chiefs.

Learning and using standard terminology helps reduce confusion between the day-to-day position occupied by an individual and his or her position at the incident. The titles for all supervisory levels of the organization are shown in the table below.

Organizational Level	Title
Incident Command	Incident Commander
Command Staff	Officer
General Staff (Section)	Chief
Branch	Director
Division/Group	Supervisor
Unit	Leader
Strike Team/Task Force	Leader

First Arriving Unit (Initial IC until relieved by higher authority)

- Performs size-up
- Gives a brief radio report
- Initiates the MCI Plan when necessary
- Directs MCI scene set-up
- Requests additional personnel for purposes of triage
- Calls for additional assistance if necessary
- Maintains role of Incident Commander until relieved
- Supervises litter bearers

First Arriving Unit (Driver)

- Isolates walking wounded, if possible
- Triage remaining patients, using the START system
- Establishes a funnel point
- Maintains role of Triage Team Leader until relieved

Incident Commander (IC)

Consistent with the National Response Framework, the IC is responsible for all activities at an incident.

- Ensuring clear authority and knowledge of agency policy
- Ensuring incident safety
- Establishing an Incident Command Post
- Obtaining a briefing from the prior IC and/or assessing the situation
- Establishing immediate priorities
- Determining incident objectives and strategy (IAP) to be followed
- Establishing the level of organization needed, and continuously monitoring the operations and effectiveness of that organization
- Managing planning meetings as required
- Approving and implementing the Incident Action Plan
- Coordinating the activities of the Command and general staff
- Approving requests for additional resources or for the release of resources
- Approving the use of participants, volunteers, and auxiliary personnel;
- Ordering demobilization of the incident when appropriate
- Ensuring incident after-action reports are complete
- Authorizing information release to the media

Safety Officer

- Reports directly to the Incident Commander
- Must have incident specific training/knowledge
- Identifies and causes correction of occupational safety and health hazards
- Ensures safety messages and briefings are made
- Exercises emergency authority to stop and prevent unsafe acts
- Review the IAP for safety implications
- Assign assistants qualified to evaluate special hazards
- Initiate preliminary investigations of accidents within the incident area
- Review and approve the Medical Plan

Public Information Officer (PIO)

- Responsible for formulating and disseminating factual and timely information about the incident to the news media and other appropriate agencies
 - ❖ Prepares public information releases (upon IC's approval)
 - ❖ Establishes a single phone number that should be released to the public for information
 - ❖ Other personnel should not give statements to the media unless authorized by the PIO
- Determines according to directions from the IC, any limits on information released
- Arranges for tours and other interviews or briefings that may be required
- Maintains current information, summaries, and/or displays on the incident

Liaison Officer

- Responsible for interacting (by providing a point of contact) with the other agencies and organizations involved in a disaster
- Maintains a list of assisting and cooperating agencies and agency representatives
- Assists in setting up and coordinating inter-agency contacts
- Monitors incident operations to identify current potential inter-organizational problems
- Provides agency specific demobilization information and requirements

Operations Section Chief

- Responsible for managing all tactical operations at an incident
- Must have incident specific training/knowledge
- Performs duties as directed by the Incident Commander
- Ensures safety of tactical operations
- Develops operations portion of the IAP
- Requests additional resources to support tactical operations
- Makes or approves changes to the IAP

Staging Manager

- Keeps a current inventory of all resources for his/her staging area
- Arranges a staging area where personnel and resources that are not immediately needed can be positioned to await an assignment
- Maintains communications with the Transport Team Leader to supply necessary ambulances, as well as to advise on available resources and send requested resources to the scene

Medical Group Supervisor

- Responsible for developing a Medical Group necessary to manage multiple casualty patients
- Coordinates triage, treatment, transportation, staging, and morgue operations
- Ensures adequate resources are requested/assigned within Medical Group
- Accounts for the personnel assigned to the Medical Group
- Maintains records and forward them to the IC

Treatment Group Supervisor

- Responsible for supervising treatment and prioritizing patients for transport
- Establishes treatment area(s) and/or patient loading area(s)
- Ensures adequate resources to treat patients
- Coordinates patient loading with Transportations Officer
- Maintains documentation of activities within treatment area
- Identifies and directs specific treatment unit leaders as necessary

Triage Group Supervisor

- Responsible for directing and coordinating triage activities
- Assigns early arriving EMTs to initiate field triage
- Ensures that all patients are tagged
- Directs movement of patients to treatment/transport area
- Ensures adequate resources necessary to conduct triage activities

Transportation Group Supervisor

- Responsible for coordinating the loading and transporting of all patients from the incident site
- Ensures adequate resources for transportation of all patients
- Directs the movement of transport units between staging and loading areas.
- Documents patient destination, departure time, and transporting agency

Morgue Unit Leader

- Responsible for coordinating the management of the deceased
- Coordinates morgue duties with local police and County Coroner
- Assures security of the personal effects and bodies of the deceased
- Coordinates disposition of patients who die in the treatment area
- Maintains documentation of morgue activities

Air Operations Group Supervisor

When available, air transportation of the injured may greatly enhance survivability of severely injured patients.

- The transportation Group Supervisor may assign an Air Transport Group Supervisor who will be responsible for:
 - Landing zone selection
 - Communication with the arriving aircrews
 - Providing security of the LZ
 - Assisting in the loading of the aircraft
 - Coordination and tracking of patient's destinations with the Transportation Group Supervisor

INCIDENT COMMANDER

(Preferred Level: Appropriate training and experience for incident type, supervisory experience)

MISSION: Responsible for the overall management and coordination of personnel and resources responding to the incident.

Tasks:

- ✓ Assumes command and announces name and title to the communication center
- ✓ Dress in identifying vest
- ✓ Identify potentially hazardous situations
- ✓ Assess current situation
- ✓ Estimate number of patients
- ✓ Request additional manpower and equipment as appropriate
- ✓ Mark Incident Command Post (ICP) with green light
- ✓ Transition to Unified Command when appropriate
- ✓ Initiate, maintain and control communications
- ✓ Assign ICS functions
- ✓ Develop, evaluate and revise operational plans
- ✓ Coordinate with other agencies

Name/Unit	Position	Radio Frequency
	Operations	
	Staging	
	EMS/Medical Branch	
	Triage	
	Treatment	
	Transport	
	Safety	
	Extrication	
	Public Information	

HELPFUL HINTS

- * Use face-to-face contact when possible
- * Many units will be coming in so be sure to establish a staging area
- * Appoint a STAGING OFFICER early on to handle this for you if necessary
- * Remember the ICS concept – you cannot do it all!
- * As tasks are completed, move people onto other tasks
- * Extended incidents will require many planning and tactics meetings

INCIDENT COMMANDER

OPERATIONS SECTION CHIEF

(Preferred level: Appropriate training and experience for incident type, supervisory experience)

MISSION: Responsible for the implementation of the IAP and creating tactics

Tasks:

- ✓ Meets with IC/UC to assist in creating IAP
- ✓ Dress in identifying vest
- ✓ Identify potentially hazardous situations
- ✓ Create tactics to accomplish incident objectives
- ✓ Brief key personnel on tactics
- ✓ Request additional manpower and equipment as appropriate
- ✓ Maintain and control communications
- ✓ Assign ICS functions as directed by IC
- ✓ Develop, evaluate and revise operational plans with IC
- ✓ Coordinate with other agencies

Name/Unit	Position	Radio Frequency
	Operations	
	Staging	
	EMS/Medical Branch	
	Triage	
	Treatment	
	Transport	
	Safety	
	Extrication	
	Public Information	

HELPFUL HINTS

- * Use face-to-face contact when possible
- * Many units will be coming in so be sure to establish a staging area
- * Appoint a STAGING OFFICER early on to handle this for you if necessary
- * Remember the ICS concept – you cannot do it all!
- * As tasks are completed, move people onto other tasks

OPERATIONS SECTION CHIEF

MEDICAL COMMAND/MEDICAL BRANCH DIRECTOR

(Preferred level: Paramedic, PHRN, or Pre-Hospital Physician with supervisory experience)

MISSION: To ensure that supervision and coordination is provided for triage, treatment, transportation and extrication of all patients.

Tasks:

- ✓ Assume command of EMS/MEDICAL BRANCH
- ✓ Report and provide frequent updates to the OPERATIONS CHIEF
- ✓ Determine main Base/Coordinating Hospital
- ✓ May also have the role of Incident Command on small incidents
- ✓ Dress in identifying vest
- ✓ Locate in a visible position
- ✓ Coordinate, direct and manage all EMS/MEDICAL BRANCH departments
- ✓ Account for all personnel assigned to this group
- ✓ Monitor safety and welfare of group personnel
- ✓ Consider relief crews
- ✓ Request separate ambulance staging area if needed
- ✓ Consider Casualty Collection Point or Alternate Care Sites
- ✓ Appoint and assign EMS/MEDICAL BRANCH SUPERVISORS and support staff:

Name/Unit	Position	Radio Frequency
	Incident Command	
	Operations	
	Staging	
	Triage	
	Treatment	
	Transport	
	Safety	
	Extrication	
	Public Information	

*On small incidents this position may also be the INCIDENT COMMANDER position

HELPFUL HINTS

* Consider having a Medical Command Physician report to the scene for onsite medical direction

MEDICAL COMMAND/MEDICAL BRANCH DIRECTOR

STAGING AREA MANAGER

(Preferred level: Appropriate training and experience for incident type, supervisory experience)

MISSION: To maintain separate stockpiles of manpower, reserve equipment and expended equipment at a staging area away from the incident.

Tasks:

- ✓ Establish STAGING AREA in coordination with OPERATIONS and/or COMMAND
- ✓ Establish the STAGING AREA at a site away from the scene.
 - The STAGING AREA should:
 - Be large enough to handle the expected number of units
 - Have easy access and egress
 - Be close to major transportation routes
 - Have easy access to the TRANSPORTATION AREA
- ✓ Provide appropriate vehicles, equipment, and resources as requested
- ✓ Order all personnel to remain with their vehicles
- ✓ Maintain and document the status of number and types of resources in STAGING

HELPFUL HINTS

*Maintain communications with EMS/MEDICAL BRANCH and TRANSPORTATION LEADER

*Consider options for alternate transportation vehicles (buses, etc.)

*Consider options for removing medical supplies from vehicles for relocation to equipment

stockpile area:

- | | |
|-------------------|------------------|
| Backboards/Straps | Splints/Bandages |
| Blankets | Oxygen Supplies |
| IV Supplies | Others as needed |

**ENSURE THAT AMBULANCE COTS ARE NOT REMOVED FROM UNITS

<u>EQUIPMENT CHECKLIST</u>	
“STAGING MANAGER” Vest	
“STAGING” Vest(s)	Barricade Tape
Portable Radio	Staging Sector Forms
Clipboard(s)	Road Cones

STAGING AREA MANAGER

TRIAGE GROUP SUPERVISOR

(Preferred level: Paramedic, PHRN, Pre-Hospital Physician with supervisory experience)

MISSION: To assess and sort casualties to appropriately establish priorities for treatment and transportation.

Tasks:

- ✓ Report and provide updates to EMS/MEDICAL BRANCH DIRECTOR
- ✓ Dress in identifying vest
- ✓ Locate in a visible position between the incident site and the treatment area
- ✓ If danger exists, ensure all patients are moved out of INCIDENT AREA before establishing TRIAGE
- ✓ Establish controlled pathway (“cattle shoo”) from the incident site to the treatment area
- ✓ Direct walking wounded to designated treatment area
- ✓ If START/JumpSTART not yet completed by first arriving crews, appoint triage teams to perform START/JumpSTART using triage tags
- ✓ Coordinate the transfer of patients to TREATMENT area with EXTRICATION. Request “porters” from INCIDENT COMMAND (or EMS/MEDICAL BRANCH DIRECTOR) as necessary
- ✓ Appoint “porters” to transport patients via backboards to treatment area. This function may be performed by personnel from the EXTRICATION/RESCUE Group. Coordinate with EXTRICATION/RESCUE
- ✓ Maintain communications with EMS/MEDICAL BRANCH DIRECTOR and other OFFICERS

HELPFUL HINTS

- *Continue START/JumpSTART until all patients have been triaged. Have triage teams work in an orderly fashion.
- *Move all **RED** patients to the TREATMENT AREA first, unless tight quarters necessitate moving others first in order to gain access to **RED** patients
- *Move **YELLOW** patients next
- *Have **GREEN** patients walk to a designated location at the TREATMENT AREA
- *Leave all **BLACK** tag patient(s)
- *Once a triage tag is applied and color identified the triage ribbons may be removed.

<u>EQUIPMENT CHECKLIST</u>	<u>TRIAGE KIT(S)</u>
“TRIAGE SITE SUPERVISOR” Vest	Triage tags
“TRIAGE” Vest(s)	4x4 Dressings (25)
Portable Radio	2” Tape (2)
Clipboard(s)	4” Kling (2)
Lighting	Oral Airway Set
Grease Pencils/Marking Pens	Vaseline Gauze (3)
	Colored Ribbons

EXTRICATION/RESCUE TASKFORCE LEADER

(Preferred level: Appropriate training and experience for incident type, supervisory experience)

MISSION: To ensure the safe and rapid removal of entrapped patients and their prompt delivery to treatment area.

Note Contaminated patients must be decontaminated prior to being moved to triage or treatment areas

Tasks:

- ✓ Report to and provide updates to OPERATIONS OFFICER or EMS/MEDICAL BRANCH DIRECTOR
- ✓ Dress in identifying vest
- ✓ Locate in a visible position with clear view of overall extrication operation
- ✓ Supervise and coordinate the EXTRICATION process
- ✓ Assist TRIAGE UNIT LEADER in determining if triage can be conducted at the incident site or if victims must be moved to a safe area prior triage
- ✓ Locate and remove trapped victims/patients and deliver them to the treatment area
- ✓ Assist in determining need for emergency medical care for patients undergoing extended/delayed extrication and request additional medical resources
- ✓ Maintain patient and team safety during all phases of the EXTRICATION
- ✓ Request relief crews to maintain progress towards extrication objectives
- ✓ Request specialized equipment and/or supplies through OPERATIONS or LOGISTICS
- ✓ Request additional manpower and/or fire suppression personnel to protect entrapped victims during the EXTRICATION process.
- ✓ Provide essential and frequent progress reports to TRIAGE and EMS/MEDICAL BRANCH DIRECTOR as appropriate

HELPFUL HINTS

*If in hazardous are, EXTRICATE patients rapidly and move to TREATMENT AREA

*Maintain close contact with TRIAGE and TREATMENT UNIT LEADERS

*Assist TRIAGE in orderly transfer of patients to TREATMENT area moving ALL **RED** TAGS FIRST

*Assist TREATMENT and TRANSPORTATION OFFICERS in moving patients when all extrications are complete (if needed)

EXTRICATION/RESCUE TASKFORCE LEADER

TREATMENT GROUP SUPERVISOR

Preferred level: Paramedic, PHRN, Pre-hospital Physician with supervisory experience

MISSION: Provide continuing assessment, triage, and care to patients awaiting transportation

Tasks:

- ✓ Report and provide updates to the EMS/MEDICAL BRANCH DIRECTOR
- ✓ Dress in identifying vest
- ✓ Locate in a visible position
- ✓ Establish TREATMENT area
- ✓ Triage patients constantly. Initially use the START/JumpSTART method, but apply more detailed assessments as Secondary Triage is initiated
- ✓ Verify triage tags as patients are moved into the treatment area
- ✓ Appoint immediate, delayed and minor care managers as needed
- ✓ Work with TRANSPORTATION UNIT LEADER to determine appropriate order of transport
- ✓ Constantly reassess patients' conditions and priorities
- ✓ Consider requesting medical Command Physician to area for on-site medical direction

HELPFUL HINTS

- *Arrange and clearly mark TREATMENT Area. Patients should be placed in parallel rows based on triage category
- *Identify areas for each triage category using colored tarps, flags, tape, etc.
- *Isolate emotionally disturbed patients
- *Have "WALKING WOUNDED" (GREEN) move to an out-of-the-way area
- *Continuously triage ALL patients. Remove ribbons once tags applied since patient conditions may have changed
- *Assign appropriate medical personnel to treatment area. Consider establishing special teams (i.e. IV teams, Bandaging teams, etc.)
- *Maintain contact with TRANSPORTATION GROUP SUPERVISOR and assist in moving patients to transportation area
- *Establish "cattle chutes" staffed with triage personnel as "gatekeepers" at entrance to and exit from TREATMENT AREA to control patient flow

<u>EQUIPMENT CHECKLIST</u>	
"TREATMENT TEAM LEADER VEST"	Treatment Sector Forms
"TREATMENT" Vest(s)	Grease Pencils/Marking Pens
Portable Radio	Barricade Tape
Clipboard(s)	Treatment Flags/Tarps
Lighting	Treatment Supplies

TRANSPORTATION GROUP SUPERVISOR

(Preferred level: Appropriate training and experience for incident type, supervisory experience)

MISSION: To assign patients from the TREATMENT AREA to incoming ALS/BLS/Mass transport units and utilize the transportation tracking log to track each patient. To also advise of the hospital destination to those units and to the dispatch center.

Tasks:

- ✓ Establish Ingress, a patient loading zone, and Egress for transport units in coordination with the STAGING AREA MANAGER, OPERATIONS CHIEF, and/or COMMAND
- ✓ Establish the LOADING ZONE in a large open area.
 - The LOADING ZONE should:
 - Be large enough to handle the multiple units
 - Have easy ingress and egress
 - Be close to major transportation routes
 - Have easy access from the STAGING AREA
- ✓ Request appropriate vehicles and resources as needed
- ✓ Order all personnel to remain with their vehicles
- ✓ Work with the TREATMENT GROUP SUPERVISOR in prioritizing patients
- ✓ Maintain and document each patient, the unit they are placed in, and the destination

HELPFUL HINTS

*Maintain communications with EMS/MEDICAL BRANCH and TREATMENT GROUP SUPERVISOR

*Consider options for alternate transportation vehicles (buses, etc.)

*Consider requesting medical supplies from vehicles that are inbound:

- | | |
|-------------------|------------------|
| Backboards/Straps | Splints/Bandages |
| Blankets | Oxygen Supplies |
| IV Supplies | Others as needed |

**ENSURE THAT AMBULANCE COTS ARE NOT REMOVED FROM UNITS

<u>EQUIPMENT CHECKLIST</u>	
“TRANSPORTATION SUPERVISOR” Vest	Barricade Tape
Portable Radio	Transportation Log Forms
Clipboard(s)	Road Cones

TRANSPORTATION GROUP SUPERVISOR

MCI OPERATIONS

EOC ACTIVATION

Local Emergency Operation Centers will become operational when an incident will require many of the infrastructure resources of the governmental entity. In the event that no local EOC exists or is rendered incapable of operating, then the local jurisdictions county will activate that counties EOC. If it is determined by that counties EOC that a higher level of assistance is required, then that EOC will request state EOC assistance and resources. It is expected that it will take a minimum of one to three hours to ramp up the staffing and functionality of the EOC. The Incident Command must realize and expect that they must operate independently during that time frame. This does not mean that the Incident Commander cannot request additional assistance. It is just that requests, rather than going through the EOC, must be made by other means, such as:

1. Local EOC's will be activated per local Standard Operating Guidelines. (SOG's), or Policies and Procedures (P&P's)
2. County EOC's will be activated per local request, state per county request

COMMUNITY WIDE OPERATIONS

Administration of the responding agency must be cognizant of the need to continue providing service to the remaining community. An example would be back filling stations with mutual aid providers. If all local and mutual aid resources are being directed at a specific incident, the State office May be contacted to coordinate outlying resources to cover the remaining community. This coordination needs to be handled separately from the Incident Command (i.e. all incident communications should be handled on one frequency while, if possible, community services and incoming resources should be handled on another frequency). Incoming community resources should report to a resource assembly point to await assignment.

PLAN ACTIVATION

- *When* to activate the plan
 - A single site Incident that overwhelms the initial responders' overall resources
- *Who* can activate
 - Any fire, law enforcement, or EMS personnel that have arrived on scene, assessed the scene, and assumed Incident Command
- *How* to activate the plan
 - Report to your communications center the level of MCI that you have on scene and that you will be assuming the IC role
 - Communications center will activate CareFlites EOP
 - Provide the following information to the communication center
 1. Type of incident (MVA, WMD, HazMat, Active Shooter, etc)
 2. Location of the incident (Name the incident by location)
 3. Best routes for Ingress and Egress
 4. Approximate number of patients involved
 - Give a START Triage Tag color count (i.e. 6 red, 10 yellow, 20 green, 4 black)
 5. Need for specific additional resources
- Specify What Needs You Have (do not use acronyms). Tell the Communications Center What Exactly You Need as the response expands:
 - 1. Special rescue equipment
 - 2. Additional manpower
 - 3. Public works (heavy machinery, work force, trucks, etc.)
 - 4. Utilities (Electric lines down, gas leak, water main break)
 - 5. Lighting
 - 6. Additional ambulances
 - 7. Search and Rescue Teams
 - 8. Disease prevention (i.e. vaccinations, sanitation, etc.)
 - 9. Medical Examiner assistance
 - 10. Mass care resources (EMS personnel, cots, blankets, medical supplies, etc.)
 - 11. EOC Activation at Local, County and/or State level.

EMS OPERATIONS DURING HAZARDOUS CONDITIONS

Purpose

To provide guidance to CareFlite personnel regarding operations prior to and during hazardous weather conditions in hopes of minimizing the risk to all field personnel.

Operational Phases

The Operational Plan when hazardous weather is likely to affect any part of CareFlites service area and the affected area of CareFlites personnel is divided into two phases:

Phase A, the Preparation Phase, shall be declared when:

- There is a potential for adverse weather arriving within 12 to 36 hours; OR
- A severe weather advisory (i.e., watch or warning) has been announced by the National Weather Service; OR
- When predicted or actual severe weather conditions can be reasonably expected to affect operations

Phase B, the Implementation Phase, shall be declared when:

- Actual emergency conditions are imminent or present; OR
- Weather and/or traffic conditions are having an adverse effect on operations; OR
- When a Weather Emergency has been declared by the Governor, municipal leader, or local EOC

Phase A

1. An Incident Action Plan (IAP) should be developed in cooperation with other local public safety agencies and the local Emergency Management Team.
2. Ensure ample fuel supply for operations prior to, during, and post event
3. Test all power equipment (e.g. generators and emergency lighting)
4. Ensure all deliverable supplies are at levels to sustain operations prior to, during, and after the event
5. Secure loose items in and around buildings
6. Ensure all personnel have the appropriate level of PPE available to them (Including helmets, work gloves, eye protection, hearing protection, rain-gear/rescue turn-outs, ANSI vests)
7. Ensure proper work schedules to allow for sleep/rehab of personnel during multi-day events
8. Ensure EMS is represented at local EOC
9. Ensure all personnel move personal vehicles to safety
10. In conjunction with the local EOC and other local public safety agencies, notify the public if responses could potentially be compromised
11. Notify personnel of impending event and of any recall plans
12. Implement recall plans if necessary
13. Have sufficient supplies on hand to rehab personnel (Food, Water, Clothing, Toiletries)
14. Supply units with food & water if there is a potential for the personnel to be cut-off from other resources

15. Develop in conjunction with municipal leaders, leaders of other public safety agencies, and the local EOC a plan describing the point at which emergency responses will be reduced or cease entirely, specifically:
 - What conditions must be present
 - How reduced/suspended responses will be communicated to all personnel
 - How dispatchers will communicate to 911 callers
 - At what point responses will resume and how this will be communicated
 - Once responses are resumed, how requests will be prioritized, to include call backs to verify the request
16. Personnel should arrange for the safety of family members to alleviate themselves of the stress of worrying about loved ones
17. Personnel should be prepared to be self-sufficient for up to 72 hours including food, water, and personal items
18. Personnel should monitor their radio and/or MDT (mobile data terminal) as appropriate for important updates and messages
19. Personnel should provide updates to dispatch of road conditions and of any hazards

Phase B

1. Personnel should use extreme caution and limit speed when driving
2. Appropriate equipment should be carried by personnel depending on the event, e.g. rain gear, cold weather gear, gloves, and deicer in cold weather events
3. Operating units should notify dispatch and other responding units of any hazardous or potentially hazardous conditions they are encountered
4. Generators used to power stations in the event of power outages should be placed outside and elevated to prevent carbon monoxide poisoning
5. Local EOCs should be notified of specific problems that CareFlite encounter within their geographic area
6. Dispatch should ensure timely transmission of announcements of the current contingency phase, hazardous driving condition warnings, and all other bulletins and messages appropriate to the current weather contingency phase
7. Personnel should not ride alone during hazardous weather conditions; all personnel should operate in pairs
8. Prior to weather conditions reaching hazardous levels, CareFlite management who feel the situations encountered are sufficiently dangerous to the safety of personnel should consult with the leaders of the other local public safety agencies to potentially reduce or cease operations.
9. Determine reducing or ceasing response operations in consultation with the incident commander, all local public safety agencies, the medical director, and municipal leaders when conditions warrant

Ceasing Emergency Response Operations

Responding at the height of hazardous weather events risks the safety of the personnel, the emergency services infrastructure critical for sustaining long-term response and recovery efforts, and even the short- and long-term safety of citizens they mean to protect.

CareFlite management will notify Dispatch, on duty crews, the Medical Director, and other emergency response agencies when responses are to be ceased. Management will also give an estimated time frame as to when responses will resume.

Resuming Emergency Response Operations

Discussions should be held with the incident commander, all local public safety agencies, emergency management, the medical director, and municipal leaders to determine when emergency operations shall resume.

CareFlite will consider the following when resuming emergency operations:

1. Ensuring adequate resources for safe response
 - a) Outside agencies resources such as public works, fire/police, etc.
 - b) Mutual Aid resources to assist with "stacked" calls
 2. Determine method of prioritizing "stacked" calls
 - a) Which are most critical
 - b) Call backs done to ensure priorities
 - c) Respond to every call even if caller refuses or states patient left scene
-

Safety determinates for modifying EMS response during hazardous conditions:

1. Safe vehicle operations:

Sustained winds, significant gusts, and Tornadoes that can cause:

- emergency vehicles to experience course deviations which can lead to accidents or vehicles being blown off the road
- ambulances to overturn
- dangerous situations to the personnel by falling trees and flying debris which can cause serious injury and/or death
 - sustained winds reach 50 miles per hour or greater
 - wind gusts reach 65 miles per hour or greater
 - Conditions of roadways
 - Snow depths and/or ice that prevent safe travel
 - Flooding of roads
 - Debris such as falling trees, etc.

2. Visibility:

Conditions that prevent operators from safely visualizing the road

- Downpours, sheets of heavy rain
- Blizzard conditions
- Heavy fog or smoke with zero or significantly limited visibility

3. Flooding:

Work related hazards that must be considered by CareFlite management in flood conditions include:

- Trauma/Drowning
- Electrical hazards
- Carbon monoxide hazards
- Musculoskeletal hazards
- Heat stress
- Motor vehicle hazards
- Hazardous materials
- Fire hazards
- Confined spaces
- Falls

Sustained High Winds, Wind Gusts, and Tornado Information Guide:

Effect of winds on the performance of emergency vehicles is not the limiting factor when making an emergency response decision. The wind's effect on rescue personnel maybe the key-limiting-factor, even more so then flying debris. Sudden gusts even at low wind speed can affect the ability for personnel to work effectively.

Although emergency vehicles could be operated in high winds, other factors would limit their operations. Hazards including debris in the air and on the roads, flooding and the difficulty in working outdoors in severe winds and heavy rains would play more of a role in emergency response than exclusively evaluating wind conditions on emergency vehicles.

Tornados:

At a localized level, a tornado is the most destructive of all atmospheric phenomena.³⁴ Tornados are measured in the Fujita or F Scale of wind damage intensity. The range is from F0 (40 to 72 mph) to F5 (261 to over 300 mph). Most tornados form between March and September and often are associated with violent weather such as thunderstorms. These storms have the potential for causing catastrophic damage to anything in their path. Weather forecasters can warn residents when conditions become conducive for tornados to develop and, with the ever-improving technology of Doppler radar it is possible to detect the formation and likely path of tornados. Despite these measures, tornados develop quickly with relatively little, if any, advance notice.

If a tornado travels through a residential area, there is the likelihood that people could become trapped in damaged homes. Fire departments may be faced with multiple collapsed buildings and rescue emergencies. Tornados may travel for several miles causing a linear event that can cross jurisdictional lines. Mutual-aid agreements may be compromised as the damage path becomes more widespread. Tornados can cause especially challenging problems for smaller jurisdictions. Recovery efforts may go on for days as search and rescue presents a lot of dangers with unstable debris.

Ice Storms and Extreme Cold:

The NWS defines an ice storm as "A form of winter storm where ice accumulates 1/4 inch or more." The accumulation of ice, especially on power lines, and on trees that fall on power lines, can cause major disruptions to electrical and telephone service. Until the streets can be treated with sand, salt, or other chemicals, the roads may be impassible to vehicles without tire chains. Motor vehicle accidents will increase until the roads are safe, while EMS and fire departments can expect requests to assist people who are stranded in their homes or vehicles. Power outages force people to seek other means for heating their homes, often with deadly results. Unvented generators or other improvised heating systems may cause structure fires or carbon monoxide poisoning.

After an ice storm, if thawing is rapid and begins before power is restored, there is an increased risk of flooding, especially in properties protected by sump pumps. EMS calls go up for ice-related injuries caused by falls (fractures, sprains, etc.). In severe cases, communities may need to open special shelters to protect indigent populations, and EMS support for these shelters may be required.

Extreme cold and ice will complicate EMS operations in several ways:

- Roads are less passable or altogether impassible from heavy ice on the roadway or from broken water mains that flood and then freeze.
- Snow and ice present operational hazards to on-scene personnel (slips, falls).
- Equipment and apparatus will be more susceptible to damage.
- Improvised heating systems may cause more fires or carbon monoxide poisoning, placing additional service demands on emergency services.
- The risk of hypothermia for both EMS and civilians increases.

Emergency service personnel must take precautions to limit exposure to extreme cold. This often is accomplished by rotating crews more often and providing heated rehabilitation areas. It also is recommended that personnel have an extra change of dry uniforms and protective clothing.

Drought and Extreme Heat:

Just as extreme cold and ice will complicate fire department operations, extreme heat and droughts can cause problems too. Extreme heat is an additional stressor for personnel and equipment. EMS service requests likely will increase, especially from the elderly and others with respiratory and heart problems. In urban areas the problem is even more pronounced, because people are more likely to keep windows or doors open when there is no air conditioning.

CareFlites Emergency Response Plan (ERP)

THIS PLAN SHOULD BE UTILIZED WHEN 3 OR MORE MICU'S RESPOND TO AN INCIDENT. MANY OF THESE TASKS ARE DONE SIMULTANEOUSLY

1. The first-in MICU crew must:
 - Quickly initiate a Scene Safety Survey
 - Promptly report a SIZE-UP AND FOLLOW-UP
 - Initiate the Incident Command System and maintain early and continuous contact with the Incident Commander
 - Assume Incident Command or Medical Command until relieved by a higher authority
 - Name the incident (it's common to name the incident by its location)
 - Request an MCI radio channel or tactical channel designation from Comm Ctr.
 - For all locations EXCEPT for Hill County
 - ❖ EMS 1
 - For Hill County
 - ❖ Scene 1
 - When applicable (for Haz-Mat or fire) request weather information
 - Wear ICS vest and utilize the MCI Kit contents
 - Establish, identify and outline EMS Group Site (Remember, be in the "COLD ZONE", up-wind and up-hill of Haz-Mat or fire);
 - Minor Injury Site
 - Triage and Treatment Site
 - Transport (Loading) Site
 - Staging Site (out of site of the incident)
2. The first-in Primary Medic will assume the positions of Medical Command (until relieved by CareFlite Supervisor and *could* double as Treatment Group Supervisor in small incidents
3. The first-in Secondary Medic will assume the positions of Triage Group Supervisor and *could* double as Transport Group Supervisor in small incidents
4. When the scope of the incident requires delegation of functions:
 - a. The second-in Primary Medic will assume the Transportation Group Supervisor position
 - b. The second-in Secondary Medic will join the Triage group
5. The first arriving CareFlite Supervisor will obtain a situation briefing from the first arriving unit that established Incident Command or Medical Command, will assume the role of medical command, and will then evaluate the effectiveness of the EMS activities and personnel and will then report to the overall Incident Commander, if applicable
6. SMART Triage is initiated
7. CareFlite units will be dispatched by Communications Center personnel only
 - a. Freelancing of units (self-dispatching) creates many operational issues and will not be allowed

IF THE FIRST-IN CREW HAS BECOME OVERWHELMED, THE NEXT-IN CREW SHOULD BE PREPARED TO ASSIST WITH OR TO PERFORM THE ABOVE DUTIES. FLEXIBILITY IS KEY IN EFFECTIVE MANAGEMENT OF THESE INCIDENTS.

The importance of the first-in MICU cannot be overstated. This crew has a 5-10 minute window of opportunity to gain control of the scene before multitudes of responders descend upon them. If this crew implements the ERP early, the incident can flow smoothly. If this does not happen, some, if not all, of the pitfalls can and will occur.

THE SIZE-UP AND FOLLOW-UP

Performing an accurate *Size-Up* and *Follow-Up* in the early stages of a MCI is very important because the Communications Center, management, and other field crews must know what you are dealing with to respond appropriately. A prompt *Size-Up* and *Follow-Up* helps to begin mobilization of additional resources and can prevent you from being surprised when important information is learned later in the incident (i.e. more victims suddenly appear on your scene, patients are located in multiple sites or a hazardous situation exists).

During the *Size-Up* and *Follow-Up* phase of the incident, it is critical that the Primary and Secondary medics remain together. Communication between both crewmembers is especially important during this phase so that they both share the same knowledge. Without shared knowledge and a team approach, the *Size-Up* and *Follow-Up* is frequently inaccurate and mistakes become greatly magnified as the incident progresses.

Motor Vehicle Collisions (MVC) present special problems. Experience has shown that determining the numbers and locations of patients can be difficult. You can avoid this problem by first taking time to make certain you know exactly how many vehicles are involved. You should ask the driver of each vehicle, "How many people were in your vehicle?" If the driver is unconscious or unavailable, other occupants or witnesses can usually provide this information. Another problem with MVC's is that the vehicles and patients are occasionally some distance apart or may be entrapped. If the first-in crew waits for the First Responders to bring the patients to the *Triage and Treatment site*, not only could triage be delayed, it may also reduce the available number of personnel to assist with SMART by as much as one half. Whenever possible we should strive to centralize all the patients, at the *Triage and Treatment site*, however entrapment/extrication and location may not allow this to happen. Although we will initially triage MVC patients where they are found, we may be able to centralize them before transport if circumstances require an extended scene time. This is not an ideal situation, but a reality that we experience, therefore, in MVC's as well as other "small" incidents, consider triaging and tagging the patients where they are found.

The process of the **SIZE-UP** and **FOLLOW-UP** is as follows:

1. **The INITIAL Size-up:**
 - a. This information is gathered as the first unit arrives on scene. The information to be relayed to the Comm Center at this point is any hazardous situation and the estimated total number of victims involved in the incident, especially if the potential for multiple patients is present.

2. **Contact the Incident Commander:**

- a. In order to start things off right in an MCI, one of the most important things you can do is to initiate Command or contact the IC on scene. This cannot be overemphasized! There are a few reasons for this:
 - A. Contacting the IC establishes an atmosphere of teamwork. You will find the FD and PD personnel to be much more helpful when everyone is working together in a unified way
 - B. The IC may have very valuable information such as known or suspected hazards, an approximate patient count, locations of patients, etc. If you arrive before the IC, all known information should be relayed to him/her.
 - C. Responsibility for the overall scene rests with the IC. He/she carries considerable authority to mobilize the resources and make them work for you. He/she has the ability and resources to provide you with the manpower, equipment and scene control you will need.

3. **The Follow Up Size Up:**

- a. This information is reported when the total number of patients is determined and additional resources are requested.

After the Size-up and Follow up are performed and reported to the Communications Center, *then* the crew separates.

- Primary Medic assumes the duties of *Medical Command* and assists as the Treatment medic.
- The Primary begins to set up the sites for *Triage and Treatment, Transportation, and Staging*.
 - a. special attention must be given ingress/egress.
- The Secondary Medic/EMT assumes the duties of the *Triage Supervisor and Transport Supervisor*.
 - Historically communications and incident coordination have been common problems in many MCI's and are frequently the most difficult task. On the other hand, triage utilizing SMART is very simple.

MULTIPLE PATIENT INCIDENTS (MPI)

(Less than 10 Patients)

Incoming MICU's-

1. Respond as directed by the *Communications Center*
2. Contact *Medical Command* or *Transport Supervisor* for staging instructions
3. Report to the *Transport Supervisor* when requested to Transport Site

On Duty Supervisor

****DON'T PANIC****

1. Respond to the scene
2. Reassess the safety and *Scene Size-Up* of incident
3. Assure that a *Triage and Transport Site* has been established. If not, select appropriate site and coordinate movement of patients
(NEVER allow the *Triage and Transport site* to be moved unless a significant safety hazard to personnel and patients)
4. Assign two First Responders or bystanders to set up site identifiers (cones, signs & flags)
5. Assure that EMS personnel have been assigned and are functioning adequately. If not assigned or functioning, assign, coach, or reassign position(s)
6. Assume *Medical Command* duties, **Function as a Coach** (let personnel do their jobs)
7. Move to and Remain at the Command Post with IC

MASS CASUALTY INCIDENTS

(10 Patients or More)

****DON'T PANIC****

First and Second in MICU's-

1. Establish and perform assigned duties at the *Triage and Treatment Site*
2. Make hard equipment for patient evacuation from the *Casualty Collection Point* to *Triage and Treatment Site*.

Incoming MICU's-

1. Respond as directed by the *Communications Center*
2. Report to the *Staging Area* unless otherwise directed
3. Drop hard equipment (backboards, C-collars & CID's) if necessary

Operations Manager-

1. Respond to EOC if activated
2. Respond to scene if EOC is not activated

Medical Director-

1. Respond to EOC or EPAB
2. Issue "Standing Orders" through the *Communications Center* as indicated

Clinical Manager-

1. Report to *Medical Command* for briefing

Communications Director-

1. Respond to the *Communications Center*

Off Duty Operations Supervisors-

1. Respond as requested to support *Medical Command*

Surgical Strike Team-

The IC or MC may request that a Surgical Strike Team to respond to the scene for surgical extrications. MC will be responsible for contacting Medical Control in order to facilitate this request.

THE TRIAGE AND TREATMENT SITE

After the safety and security of the scene are assured, the *Scene Size-Up* and *Follow-up* is reported to the Communications Center. The next step is the setup of the *Triage* and *Treatment* sites. One of the most common mistakes made during an MCI is the failure to properly establish this site. Without all of the patients being in one centralized location, the medics find themselves focused on the most obviously injured patient or constantly moving from patient to patient. As a result, no effective organization is developed and the medics are overwhelmed when the multitude of additional resources descends upon them. It is the responsibility of the first-in Primary Medic, in conjunction with consultation from the IC, to select this area.

The first consideration for the location of the site is **safety**. It should be up-wind and up-hill from Haz-Mat and/or fire, away from traffic flow (but with appropriate ingress and egress), out of "**Hot Zone**", yet relatively (safely) close to IC. Terrain as well as good ingress and egress are also considerations for the *Triage* and *Treatment*. Once a *Triage* and *Treatment* site has been established, **do not allow it to be moved** unless directly ordered to do so by the overall Incident Commander or Medical Commander.

For the MPI (less than 10 victims), it **may not** be necessary to establish a formal *Triage* and *Treatment* site. For example, 6 patients from a MVC, which are all in the delayed or minimal category, simply need to be placed together. In the small MCI, the standard tarp or traffic cones carried on each fire apparatus should be of sufficient size to accommodate this number of patients. For the larger incidents, a more formal sector must be established. Large traffic cones with barrier tape are carried on most fire or police units must be used to establish this area. An entrance, exit, critical and delayed sides will be established and identified with flags or signs.

In the event that the number of patients is too large for the critical and delayed patients to be placed inside the sector, it may be necessary to establish separate sectors for each category. In addition, a temporary morgue may be established (out of sight of victims and the media) unless crime scene priorities take precedence. In the instance of multiple patients at multiple locations, several independent sites may need to be established (i.e. a tornado with a large pathway). Coordination of these separate locations should be carefully coordinated and controlled by the Medical Command personnel.

Movement of the patients to the *Triage* and *Treatment* site during the first few minutes of the incident can be difficult due to limited equipment and manpower. Each fully stocked MICU can provide equipment to move 6 patients (1 cot, 3 backboards, 1 scoop stretcher, and 1 stair chair). Spinal motion restriction will be improvised on occasion, as there will be a limited number of cervical immobilization devices available. Towel rolls or blanket rolls may be utilized. The problem of limited manpower early on in the incident can be mitigated by utilizing bystanders to help move patients to the *Triage* and *Treatment* site.

PATIENT DESTINATION ASSIGNMENTS

There are some important factors that must be considered when coordinating patient destination assignments with the Communications Center. Special patient needs may require patients to be transported to designated Trauma Centers. Pediatric patients will usually require transport to a pediatric facility). An important emotional factor is preventing family members from being separated at different facilities. The Treatment Supervisor, Transport Supervisor, and Communications Center must work together to provide for these special needs when possible.

******END OF ERP******

START TRIAGE AND RAPID TREATMENT TRIAGE

The MCI is a situation where the skills we usually use in dealing with patients on a one-to-one basis just do not apply. In fact, one of the critical factors in effective management of the MCI is changing paradigms (the mindset) from dealing with just one patient to managing an incident with many patients.

The "START System" (Simple Triage and Rapid Treatment) is a method of rapidly assessing and triaging mass casualty patients. The triage group should implement the "START" system whenever an incident involves four or more patients. Triage is a BLS skill and should be staffed by EMT's when available. Teams of two EMT's move from victim to victim performing START Triage, applying bleeding control or BLS airways if needed, applying surveyor's tapes so as to be visible from a distance, and submitting a count of victims triaged with triage category to the Triage Group Supervisor. Whenever available, a START triage belt system should be utilized to assist the rescue personnel in triaging and applying surveyor's tapes to patients. Triage team members and civilians may then become litter-bearers (under the direction of the Triage Group Supervisor) to move first the red, then the yellow taped victims to those treatment areas.

START triage begins by commanding all patients who can hear you and are "ABLE TO MOVE" to self-relocate to a safe area (the Minor Injury Site). These patients have identified themselves as "walking wounded" or GREEN and will not be further evaluated until more rescuers arrive and the more critical patients have been attended to.

One EMT or Fire Fighter should be assigned to this area for every 8-10 patients

The next component is to ask all the patients who can hear you, but are unable to walk to move something (an arm, leg or head) to do so. This identifies these patients as cognitive, just unable to self-relocate (i.e. fx leg, etc.). They may still be GREEN, but are possibly YELLOW. The next step is to evaluate and categorize the RED's from the BLUE's and BLACK's.

START is a system that quickly and accurately categorizes patients into treatment groups. It is useful in the MCI setting where there are many patients and the first rescuer on scene has to maximize his/her efficiency so that the patients can be quickly moved to treatment areas.

I-Immediate-RED: critical/life threatening, yet survivable (non-salvageable are categorized as BLUE) as dictated by the confines of overall incident resources

D-Delayed-YELLOW: serious, but stable with no imminent threats to life, limb or eye sight and as dictated by the confines of overall incident resources

M-Minimal-GREEN: minor or "Walking Wounded"

E-Expectant-BLUE: alive, but so seriously sick or injured (non-salvageable) that their survivability is exceedingly unlikely and the confines of the overall incident resources dictate that they should not consume limited available resources at this time.

However, after all of the **RED** patients have been removed from the scene, these patients may be re-evaluated to **RED**, treated and transported

D-Deceased-BLACK: dead/deceased, may (at some time) be moved to a temporary morgue, but will probably remain in place as crime scene priorities dictate.

A triage tag is fastened to the right wrist and labeled with their number immediately after triage. START begins after the crew has performed the size-up and follow-up. After the "Walking Wounded" are triaged and moved to a safe area (Green Triage location), the focus shifts to extrication. An Extrication Task Force will be responsible for removing patients from the Warm zone to the *triage and treatment site*. A *Casualty and Collection* point may also need to be established. Once patients are at the triage site, the Triage Supervisor and crew initiate the three-step triage evaluation process of START for the non-walking patients as they arrive. If the number of patients is small, the Triage crew may triage the patients as he/she moves about the scene. Be flexible and adjust to meet the needs of your scene, but as a rule, always try to centralize patients in the Triage and Treatment area.

START Triage Parameters

RESPIRATIONS are assessed first. If the patient is breathing at a rate of 30 bpm or more (by estimation) or is breathing less than 10 bpm, they are tagged **RED** (immediate) and moved to the critical side of the Triage and Treatment Site. If the patient is not breathing, one attempt to re-position the airway to stimulate respiration is performed. If the patient begins to breathe, they are tagged **RED** (immediate). If the patient is still apneic after re-positioning, they are tagged **BLACK** (dead).

CIRCULATION is then assessed for those patients who are breathing at a rate of less than 30 bpm (but greater than 10 bpm). This is performed by checking the capillary refill. If capillary refill is delayed (greater than 2 seconds) then the patient is tagged **RED** (immediate) and moved to the critical side of the sector. In situations where it is difficult to assess capillary refill, (i.e. poor lighting, cool temperatures) a reasonable alternative is to check for a radial pulse. If a radial pulse is absent, then the patient is tagged **RED** (immediate).

MENTAL STATUS is then assessed for those patients who are breathing at a rate of less than 30 bpm (but greater than 10 bpm) and have a normal capillary refill or radial pulse. If the patient cannot obey simple commands, (i.e. squeeze my hand) then the patient is tagged **RED** (immediate) and moved to the critical side of the sector. If the patient can obey commands, they are tagged **YELLOW** (delayed) and moved to the delayed side of the TRIAGE AND TREATMENT SITE.

**THE ONLY TWO TREATMENTS PERFORMED IN START ARE
RE-POSITION THE AIRWAY AND CONTROLLING OBVIOUS
EXTERNAL BLEEDING**

Treatment and Tracking

1. A *TRIAGE/Treatment tag* should be filled out in the Treatment Area for each patient, and tracking process implemented. The treatment tag should indicate priority and serve as an area in which to write vital signs, injuries, and other pertinent patient information while simultaneously beginning the tracking process. Begin treatment of casualties, immediate priority first, delayed second, and so on, in accordance with local protocols. Treatment should not delay transport unless absolutely necessary to stabilize life threatening injuries. Tracking must be initiated immediately post triage/treatment.
2. The *Treatment/Tracking Group Supervisor* is responsible for the establishment and operation of the treatment area and the initiation of all patients in to the tracking system. The location should be determined by terrain, circumstances of the incident or accident, and existing safety hazards at the site. This area should be readily accessible to ambulances but isolated from any dangerous conditions associated with the incident.
3. The *Treatment/Tracking Area* shall have a readily identifiable entrance with easy ambulance access. Signs, traffic cones, or other markers should be utilized to mark the entrance to this area. The Treatment/Tracking Area location should be made known to all members of the medical group. The Treatment/Tracking Area shall be divided into three separate zones. These zones can be readily marked with red, yellow and green barrier tape, flags or colored plastic tarps to identify the appropriate treatment/Tracking area. The *Walking Wounded Area* should be clearly visible (marked by green flags or lights) and is generally placed out of view of the other treatment areas, and within access of mass transportation such as busses. Traffic cones or barriers may be used to create approach paths for delivery of patients into these areas.
4. First arriving patients should be placed near the rear or exit to the Transportation/Tracking Area. Place all patients in an orderly manner. Adequate space should be provided between patients to allow working room for treatment personnel. Treatment personnel must provide ongoing assessment of all patients for changes in conditions to maintain appropriate triage classification and to establish treatment and transportation priorities. The Treatment/Tracking Group Supervisor should be continually updated on victims' medical and tracking status, and is responsible for relaying this information to the potential receiving hospitals and IC through the Communications Group or Unit.
5. The Treatment Area Supervisor should keep track of the treatments being performed for each patient in a *Treatment Log*.

DOA

In the case of obvious deaths at a scene, the Incident Commander will request assistance from the Medical Examiner's Office through the EOC or State EMS office. The Medical Examiner's designee shall be assigned to establish and maintain a **temporary morgue** and to carry out the necessary investigation, recovery and processing of human remains. The Medical Examiner's role will include identifying the dead and determining the cause of death.

- During initial triage, it is essential that any and all human remains be left "where found" at any accident or incident site. The exception will be if existing hazards preclude leaving the remains "where found". Bodies should be initially triage taped and then all possible data including photo documentation, concerning where and how the patient was found should be noted on a triage tag after all survivors have been transported from the scene.

Transportation

1. The **Transportation Group Supervisor** is responsible for providing and coordinating all of the patient transportation. Generally, a person from the first ambulance on scene will assume this responsibility until relieved by a supervisor or another designee. The Transportation Group Supervisor will be designated by the Medical Incident Commander.
2. The **Transportation Group Supervisor** will set up operations close to the exit of the Treatment Area and very close to where patient loading will take place. The *Transportation Group Supervisor* will work closely with the *Treatment Supervisor* in determining which patients are to be transported first. The Transportation Group Supervisor will provide the appropriate transportation, air or ground as needed or available.
3. The **Transportation Group Supervisor** needs to have radio communications with the Incident Commander, local ambulances, air ambulances and hospitals. The Communications Center can assist with this function.
4. Additional ambulances should be staged in an area that is accessible to the scene and with a clear entrance and exit. Vehicles used for transporting patients should be staged as close as possible. Extra equipment is to be off-loaded upon arrival at the staging area, to be utilized by the triage and treatment teams. Transport teams are to stay together with their ambulances.

As soon as possible, a status board and/or **Tracking log** should be initiated by the transportation group supervisor or designee, and maintained that indicates the number of patients that each local hospital is able to accept and how many patients at what level of criticality have been transported to each facility. Communications should be established with the receiving hospital as early as possible to indicate the numbers and injury severity of patients requiring transportation and treatment. A Patient Tracking Group, Unit or Resource can serve this function, and may be combined with the Hospital Communications Group, Unit or Resource.

- It is important that there are no delays in transporting patients to area hospitals. Patients are to be distributed to hospitals in such a manner that no single hospital becomes overloaded if patient numbers allow. However, if all hospitals are at capacity, they may be overloaded, and no diversion of ambulances will be permitted. All hospitals are expected to have contingency plans for MCI surge events. If necessary, two or three ambulances can be loading simultaneously, and safely, multiple patients may be transported in each ambulance. The Transportation Group Supervisor will coordinate helicopter transportation with the Air Division Supervisor.

Mass Transportation

- A large number of patients may be transported by mass transportation. The transportation officer should group those individuals who do not require immediate medical attention and transport these patients using mass transportation. These will generally fall into the GREEN or “walking wounded” category.
- Consider utilizing the following resources for mass transportation
 - AMBUS (dispatched through the RAC)
 - School buses
 - Shuttle vans

Hospital Patient Capability and Tracking Log

Use hash-marks to track number of patients transported

Hospital	Accepting Trauma Alerts	Trauma Alerts Transported	Accepting REDS	REDS Transported	Accepting YELLOW	YELLOWS Transported	Accepting GREENS	GREENS Transported

CONFIDENTIAL

MUTUAL AID

As defined earlier, a Level III disaster means that your local resources are overwhelmed or depleted. This situation calls for mutual aid from neighboring EMS jurisdictions. EMS planners must realize that their local EMS system might be expected to respond to a mutual aid request as well as being the recipient of mutual aid. Mutual aid is a very important component of disaster planning. Discussions should begin early with neighboring agencies. Written agreements may be required to be established. EMS personnel, supervisors, and dispatchers should be familiar with local mutual aid agreements. It is the responsibility of the Fire/EMS, Police, and communications chiefs to ensure that these are in place and clearly understood by all parties involved.

The Texas Statewide Mutual Aid System was established to provide integrated statewide mutual aid response capabilities between local government entities that did not have written mutual aid agreements.

Texas is a member of EMAC, a congressionally ratified organization that provides procedures for rendering emergency assistance between states. After a state of emergency declaration, Texas can request and receive reimbursable assistance through EMAC from other member states. For more information, see the Texas Emergency Management Annex (ESF-5).

Resource Requests

State of Texas Assistance Requests (STARs) connect first responders in affected areas to personnel working in the SOC. During SOC activations, requests from local jurisdictions are identified, routed, authorized and fulfilled via the Web-Based Emergency Operations Center's (WebEOC) STAR process.

MCI KITS

Each MICU is equipped with a MCI Kit. These kits are designed to assist crews by providing vests, quick-reference cards, triage tags, and paperwork.

MICU MCI KIT CONTENTS:

50 - START Triage Tags in pouch

SUPERVISOR VEHICLE KIT CONTENTS:

MCI Command Board
Landing Zone LED Lights
MCI Color Coded Tarps
MCI Safety Vests
200 – SMART Triage Tags



DOCUMENTATION

Although paperwork is the last thing we want to do during a MCI, documentation must be maintained. Since the *Transportation Supervisor* is responsible for the distribution of where patients are being transported to, they must be able to track the necessary information. The *Transportation Supervisor* is responsible for tracking and accounting for all patients. Therefore, some paperwork must be completed while the incident is active.

Incident Briefing: ICS-201

Medical Command is responsible for the completion of this report as it is required for the overall mission to be completed during an operational period.

Hospital Log:

The *Communications Center* begins documenting when receiving the Hospital Capacity Data from the various regional hospitals. Later, as transport begins, the *Communications Center* will keep track of all patients being transported to the receiving facility. This will be a raw number and not based on SMART tag tracking codes.

Multi Patient Transportation Log:

This report is invaluable for final patient tracking. It provides accurate data to the Planning Branch for Financial recovery following the incident's closure.

THE ABOVE DOCUMENTS ARE THE ONLY REQUIRED PAPERWORK TO BE COMPLETED ON SCENE WHILE THE INCIDENT IS ACTIVE

Electronic Patient Care Reports (ePCR):

The transporting MICU's are required to complete a patient record forms (iPCR or chart) for each patient transported.

ICS Forms Dissemination List

ICS Form #	Form Title:	Typically Prepared by:
ICS 201	Incident Briefing	Initial Incident Commander
ICS 202*	Incident Objectives	Planning Section Chief
ICS 203*	Organization Assignment List	Resources Unit Leader
ICS 204*	Assignment List	Resources Unit Leader and Operations Section Chief
ICS 205*	Incident Radio Communications Plan	Communications Unit Leader
ICS 205A**	Communications List	Communications Unit Leader
ICS 206*	Medical Plan	Medical Unit Leader
ICS 207	Incident Organizational Chart (Wall-mount size, optional 8 ½"x14")	Resources Unit Leader
ICS 208**	Safety Message Plan	Safety Officer
ICS 209	Incident Status Summary	Situation Unit Leader
ICS 210	Resource Status Change	Communications Unit Leader
ICS 211	Incident Check-In List (optional 8 ½"x14" and 11"x17")	Resources Unit/Check-In Recorder
ICS 213	General Message (3-part form)	Any Message Originator
ICS 214	Activity Log (optional 2-sided form)	All Sections and Units
ICS 215	Operational Planning Worksheet (optional 8 ½ x 14" and 11"x17")	Operations Sections Chief
ICS 215A	Incident Action Plan Safety Analysis	Safety Officer
ICS 218	Support Vehicle/Equipment inventory	Ground Support Unit
ICS 219-1 to ICS 219-8, ICS 219-10 (Cards)	Resource Status Card (T-Card) (may be printed on cardstock)	Resources Unit
ICS 220	Air Operations Summary Worksheet	Operations Section Chief or Air Branch Director
ICS 221	Demobilization Check-Out	Demobilization Unit Leader
ICS 225	Incident Personnel Performance Rating	Supervisor at the Incident

- A form with an asterisk "*" is typically included in the IAP.
- A form with two asterisks "**" could be included in the IAP.

HAZARDOUS MATERIALS (HAZ-MAT)

Decontamination of Hazardous Materials will be handled by the responding Fire Department.

A patient will not become the responsibility of EMS until such time that the patient has been decontaminated to the mutual satisfaction of the Senior Fire Department Officer (Incident Commander), and the Medical Command officer.

Contact with the patient will be made only by properly gowned, gloved, and masked personnel and only after proper decontamination.

Decontamination will take first priority over patient care unless a properly protected individual can provide that patient care.

CareFlite personnel do not have the protective equipment or training for decontamination. Transportation will most always occur by ground. In rare circumstances, aeromedical transportation will be considered and only after consultation with the aeromedical crew and in particular the pilot.

SPECIAL UNIT UTILIZATION

Regional MCI support can be requested through *Medical Command* or *Incident Command* based upon county agreements.

DEMOBILIZATION

Smaller incidents with limited ICS usually do not require a written demobilization plan. However, large incidents involving multi-agency or multi-jurisdictional responses do require a written demobilization plan. The demobilization plan should include:

Briefing Statement
Responsibilities
Release Priorities
Release Procedures

DEMOBILIZATION PLAN

This Demobilization Plan contains five (5) sections:

1. General Information
2. Responsibilities
3. Release Priorities
4. Release Procedures
5. Travel Information

GENERAL INFORMATION:

The response is rapidly transitioning from the emergency response phase to a planned recovery effort. The demobilization of incident resources must be conducted in an efficient and safe manner and shall not interfere with ongoing incident operations. The following will be incorporated into the demobilization effort:

- A. All releases of resources from the Incident will be initiated in the Demobilization Unit after of the approval of the Incident Commander.
- B. No resources are to leave the Incident until authorized to do so
- C. All property, including rental vehicles shall be properly returned and appropriate records forwarded to finance.
- D. Notify Logistics and Finance at least 24 hours in advance for identified resources being demobilized.

RESPONSIBILITIES:

- A. Section Chief and Unit Leaders are responsible for determining resources surplus to their needs and submitting lists to the Demobilization and Resources Unit Leader or the Planning Section Chief.
- B. The Incident Commander is responsible for:
 - Establishing the release priorities
 - Review and approve the Demobilization plan
 - Review and approve all tentative release sheets

- C. Operations Section Chief
 - Identify any excess personnel and equipment available for demobilization and provide list to
- D. Planning Section Chief
 - Identify and decontaminate all tactical resources, as needed.
 - Where possible, release resources that have pre-established shared transportation together to facilitate demobilization.
- E. Demobilization Unit Leader or (Planning Section) is responsible for:
 - Preparing the Demobilization Plan
 - Compiling "Tentative" and "Final" Release sheets
 - Making all notifications regarding tentative and final releases from the incident (on and off Incident)
 - Working with jurisdictional agency to arrange transportation
 - Ensure all signatures are obtained on the Demobilization Checkout form ICS 221
 - Monitors the Demobilization Process and make any adjustments
- F. The Safety Officer is responsible for:
 - Identifying any special safety considerations for the Demobilization Plan
- G. The Planning Section Chief is responsible for:
 - Review and approval of the Demobilization plan
- H. The Logistics Section Chief is responsible for:
 - Facilities - that all personnel scheduled for release have good facilities for proper rest
 - Facilities that all-sleeping and work areas are cleaned up before personnel are released
 - Supply: - will ensure that all non-expendable items are returned or accounted for prior to release
- I. Finance/Administration Section Chief,
 - Transportation - will ensure that there is adequate ground transportation during the release process.
 - Communications - will ensure that all radios, phones and pagers are returned or accounted for
 - Food unit leader - will ensure that there will be adequate meals for those being released and those remaining
- J. The Finance Section Chief is responsible for:
 - Completion of all personal time reports
 - Completion of all rental and agency equipment time reports
 - Contract equipment payments as required

RELEASE PRIORITIES

The following are the release priorities:

1. Personnel welfare (safety and rest)
2. Needs of the assisting/cooperating agencies
3. High dollar assets
4. Local government response resources
5. Federal government response resources

RELEASE PROCEDURES:

- A. When final approval for releases is obtained the Demobilization unit will:
 - Prepare transportation manifests
 - Notify or page Incident Supervisors and/or personnel to be released
 - Give Incident Supervisors and/or personnel the final release and briefing.
- B. Resources and/or personnel will take the Demobilization Checkout form ICS 221 to:
 - Communications Unit Leader: if communication equipment is issued
 - Transportation Unit Leader: transportation plan, rental vehicle issued, and vehicle safety inspection
 - Facilities Unit Leader: to insure all facilities are clean
 - Logistics Unit Leader: return all expendable supplies and returned
 - Finance Section: close out all personnel and equipment time records
 - Documentation Unit Leader: turn in all ICS 214's and any necessary paperwork
 - Demobilization Unit Leader: turn in ICS 221 with all the signatures
- C. Demobilization Unit will be the last stop in the release process:
 - Sign off the ICS 221 Demobilization Checkout form
 - Notify the Resource Unit so that "T" card information is complete
 - Notify local agency and home unit of ETD and ETA, destination and travel arrangements
 - Collect and send all Demobilization paperwork to the Documentation Unit

Communications Plan

Multi – Patient Incidents (MPI)

- First arriving unit will notify Communications Center of multi-patient event and establish Medical Command
- After scene size up, they will request necessary number of MICU's
- Communications will dispatch on duty Supervisor
- Communications will place two (2) aircraft on Standby and will dispatch the requested number of MICU's to location
- Communications will notify area Operations Management
- **Only** Medical Command will manage in-bound or on scene resources based upon incident need

Mass Casualty Incidents (MCI)

- First arriving unit will notify Communications Center of mass casualty event and establish Medical Command
- After size-up, Medical Command will designate the appropriate level of resources needed
- Communications will dispatch on duty Supervisor
- Communications will notify area Operations Management
- The following criteria will be used by Medical Command to request MCI resources:

MCI Level I Taskforce:	Up to 10 patients 4 Ground Units; 2 Aircraft on standby
MCI Level II Taskforce:	11 – 25 Patients 3 Additional Ground Units (7 total Ground Units); 2 Aircraft Dispatched
MCI Level III Taskforce:	26 – 50 Patients 3 Additional Ground Units (10 total Ground Units); All Aircraft in Rotation
MCI Level IV Taskforce:	51 + Patients 3 Additional Ground Units (13 total Ground Units); All Aircraft in Rotation

****Specific Resources/Units Available Upon Request****

Radio Channels

MOBILE BUTTON PROGRAMMING

BUTTON A EMS DSP
BUTTON B FIRE DSP
BUTTON C 7MED65D

L3 Harris Programming Layout

❖ KC FireA

- FIRE DSP
- FIRE 1
- FIRE 2
- FIRE 3
- AS VFD1
- CMVFD 1
- COMB FD1
- CRND FD1
- ELMO FD1
- KFD 1
- KEMP FD1
- MAB FD1
- ROS VFD1
- SCRY FD1
- TER VFD1
- FIRE DSP

❖ KC FIREB

- FIRE DSP
- FFD 1
- EMS DSP
- EMS 1
- EMS 2
- IT REKEY
- FIRE DSP

❖ KAUF FRE

- FIRE DSP
- KFD 1
- KFD 2
- KFD 3
- FIRE 1
- FIRE 2

- FIRE 3
- EMS DSP
- SCRY FD1
- TER VFD1
- KFDEVENT1
- KFDEVENT2
- KPW 1
- KPW 2
- DISP 1
- FIRE DSP

❖ TERRELL

- FIRE DSP
- FIRE 1
- FIRE 2
- FIRE 3

❖ FORNEY

- PD DISP
- FD DISP

❖ SEAGOVIL

- SFD DISP
- SFD OPS2
- SFD OPS3
- SFD OPS4
- SFD OPS5
- FIRE CALL
- FR I/O 1-10

❖ **GRMS**

- LAW CALL
- LAW I/O 1-10

❖ **BSFD**

- FD DISP
- FIRE OP1
- PD DISP

❖ **7TAC50**

- 7CALL50
- 7CALL50D
- 7TAC51
- 7TAC51D
- 7TAC52
- 7TAC52D
- Continues through 7TAC56D

❖ **7TAC60**

- 7LAW61
- 7LAW61D
- 7LAW62
- 7LAW62D
- 7FIRE63
- 7FIRE63D
- 7FIRE64
- 7FIRE64D
- 7MED65
- 7MED65D
- 7MED66
- 7MED66D
- 7DATA69
- 7DATA69D

❖ **7TAC70**

- 7TAC71
- 7TAC71D
- Through 7TAC76D
- 7GTAC77
- 7GTAC77D
- 7MOB79
- 7MOB79D

❖ **7TAC80**

- 7LAW81
- 7LAW81D
- 7LAW82
- 7LAW82D
- 7FIRE83
- 7FIRE83D
- 7FIRE84
- 7FIRE84D
- 7MED86
- 7MED86D
- 7MED87
- 7MED87D
- 7DATA89
- 7DATA89D

❖ **8-TAC**

- 8CALL90
- 8CALL90D
- 8TAC91
- 8TAC91D
- Through 8TAC94D
- 8CALL90

❖ **CNCT REG**

- NCTRG-1
- NCTRG-2
- NCTRG-3
- NCTRG-4

❖ **CNCT TAR**

- TAR-A
- TAR-B
- TAR-C
- TAR-D

❖ **CNCT DAL**

- DAL-A
- DAL-B
- DAL-C
- DAL-D

- ❖ **CNCT COL**
 - COL-A
 - COL-B
 - COL-C
 - COL-D
- ❖ **CNCT DEN**
 - DEN-A
 - DEN-B
 - DEN-C
 - DEN-D
- ❖ **BALCHSPR**
 - BSFDALRT
 - BSFDDISP
 - BSFDOPS1
 - BSFDOPS2
 - BSFDOPS3
 - BS MED 1
 - BS MED 2

COMMON PITFALLS

IF WE DO NOT USE A SYSTEMATIC APPROACH TO THESE INCIDENTS, ONE OR MORE OF THE FOLLOWING PITFALLS WILL OCCUR.

1. **FAILURE TO RECOGNIZE AN MCI EARLY:** This mistake can be very frustrating. Medics believe they have just a few patients but more trickle in as the incident progresses. This occurs frequently with Motor Vehicle Collisions, toxic inhalation, and other situations involving several victims who initially do not present as patients. The solution to this problem is twofold. First, knowing how many people (victims) were present, at the scene, when the incident occurred, can help you anticipate how many patients you can expect. Second, when you encounter an incident involving many people you should assume you will have many patients. It is much easier to downgrade an incident after a limited number of patients are confirmed than it is to coordinate an incident that must be upgraded midstream. Those who have experienced this mistake have learned to expect that there will frequently be more patients than are readily apparent. When faced with a large number of people involved in an incident, they set up for a large number of patients. This sounds simple, but it is amazing how quickly an incident can get out of control if this is not done.
2. **FAILURE TO IMPLEMENT THE PLAN:** These incidents are very different from the everyday calls we run. The basic components of "The Plan" must be assigned to specific personnel or chaos will reign. Attempting to develop a plan from scratch in the heat of the battle can be very frustrating and ineffective.
3. **FAILURE TO CONTACT THE INCIDENT COMMANDER:** The Incident Commander is your best friend during these incidents. He/she has considerable authority to mobilize the resources needed and can keep you informed of a rapidly changing situation. Early and continuous contact with the Incident Commander will keep you from having to worry about problems such as crowd control, traffic control, manpower, and transport resource just to mention a few. Disasters require teamwork, and contact with the Incident Commander is essential for teamwork to occur. Fail to work with the Incident Commander and you will be on your own, not only during the critical first few minutes, but probably throughout the entire incident.
4. **FAILURE TO ESTABLISH A TRIAGE AND TREATMENT SITE:** If a Triage and Treatment Site is not established, you will find yourself wasting a considerable amount of time and energy running around from patient to patient. Incoming personnel will not know where to find you and will frequently complicate your scene by acting independently. Changes in patient conditions will not be discovered promptly and your scene will be scattered and chaotic.

ISOLATING ALL OF YOUR PATIENTS IN ONE PLACE IS ONE OF THE MOST IMPORTANT THINGS YOU CAN DO TO CONTAIN VICTIMS AND MAINTAIN CONTROL OF THE SCENE

5. **FOCUS EFFORTS ON JUST ONE PATIENT:** If the first-in crewmembers focus (tunnel vision) on the most obvious patient, they will not establish control of the entire incident. Fluidity is essential in effective management of these scenes. Without it the results will be continued chaos and confusion.
6. **LACK OF COMMUNICATION:** Historically a lack of communication is cited as a problem in poorly managed major incidents. If the Communications Center is not informed promptly about the situation, they cannot anticipate the resources you may need. Incoming MICU's will not know who to report to, where to go, or what to do. Again, teamwork is critical in these situations and a lack of communication will result in delayed resources and confusion. The Communications Center must receive frequent updates and the incoming crews provided with necessary information.
7. **FAILURE TO ISOLATE PATIENTS OF HAZARDOUS MATERIALS:** If Haz-Mat patients are transported before decontamination, a true disaster can result. Personnel become contaminated, which at minimum can cause illness and at worse can cause death. MICU's must be taken out of service for a considerable length of time for decontamination. Entire Emergency Departments (ED's) have been closed for several hours because they were contaminated when patients were not decontaminated on scene.
8. **FAILURE TO STAGE INCOMING MICU'S:** All incoming MICU's must be staged to allow the first-in crews to gain control of the scene and set up. If this does not happen, the first-in crews are usually overwhelmed. Ingress and egress become difficult as the scene is cluttered with MICU's parked haphazardly. One exception to this is an MCI in which the third in MICU may be requested to enter the scene for treatment and staging assistance.
9. **INEFFICIENT UTILIZATION OF TRANSPORT RESOURCES:** Each transporting MICU must transport the maximum appropriate number of patients so that limited transport resources are not wasted.
10. **ESTABLISHING THE TRIAGE AND TREATMENT SITE TOO CLOSE TO THE INCIDENT:** If the Triage and Treatment Site is established too close to the incident, the confusion and chaos of the incident can overwhelm the responders. Incidents involving dozens of patients may require a Casualty Collection Point to serve as a "Buffer" between the incident site and the Triage and Treatment Site.
11. **RELOCATING THE INCIDENT TO A HOSPITAL:** Simply moving all the patients to one hospital only results in re-locating the incident. Patient care for those already in the hospital will suffer and those that are transported to the hospital will not receive quality care, because the hospital will be overwhelmed.

Appendix A

START Triage and Tags

FRONT

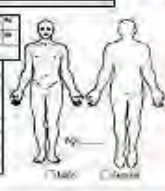
Personal Property Receipt/
Evidence Tag 55555

Destination 55555

Via 55555

TRiage TAG 55555

Death Cause
 Forensic Death
 Evidence
 Injury
 Death
 Drowning
 Fire
 Poisoning
 Other



T-Max
 C-Max

Other

VITAL SIGNS

Case	Sp	Pulse	Respiration

T-Max
 C-Max
 Other

MORGUE 55555

Police/Non-Police/Other 55555

IMMEDIATE 55555

DELAYED 55555

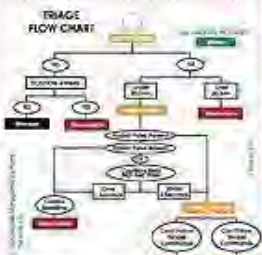
MINOR 55555

BACK

Comments/Information

Comments/Information

TRiage FLOW CHART



PERFUSION
 R
 P
 M

MENTAL STATUS
 M
 I
 U

PERSONAL INFORMATION

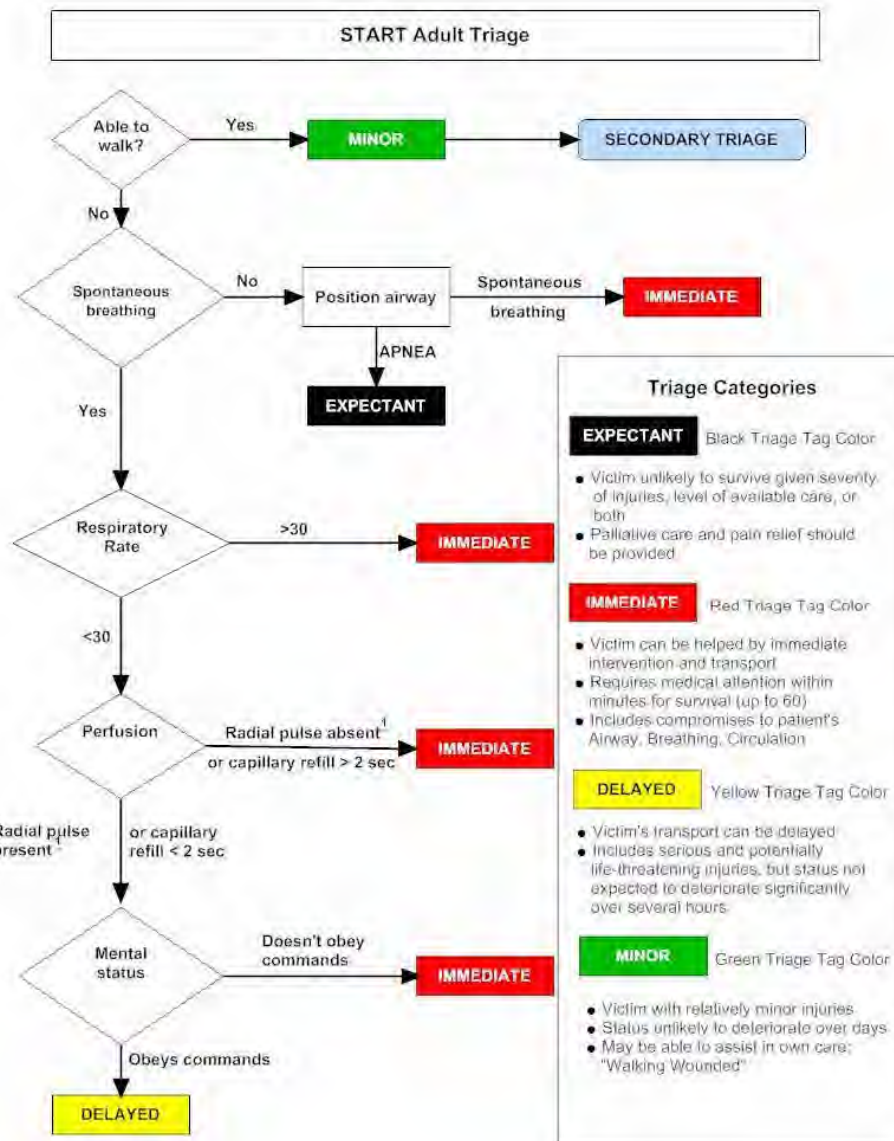
NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 PHONE _____
 COMMENTS _____

MORGUE 55555

IMMEDIATE 55555

DELAYED 55555

MINOR 55555



START BELT SYSTEM

The START belt system consists of a belt similar to a fanny pack that contains the following.

- 5m - rolls of surveyor's tape (green, yellow, red, and black)
- 4 Tourniquets

START Triage

Each victim is to be triaged using the **RPM** method.

- **R** - respiration
- **P** - pulse
- **M** - mental status

Perform a primary survey on all patients using the START method of triage. During the rapid evaluation, simple hemorrhage control and airway protection techniques are used. The only treatment should be completed by adjusting the airway or placing a dressing to stop bleeding.

Based on the primary survey findings, casualties should be prioritized. The triage team will quickly evaluate and categorize the injured into one of the following groups:

- ❖ **IMMEDIATE** (PRIORITY I) (RED TAPE): These patients are of the highest priority and are removed and treated first. These patients have severe airway, breathing, or circulation problems, or altered mental status. Examples may include:
 - Airway obstruction
 - Massive bleeding
 - Shock
 - Open chest or abdominal wounds
 - Severe head injuries
 - Severe cardiac emergencies other than cardiac arrest.
- ❖ **DELAYED** (PRIORITY II) (YELLOW TAPE): These injuries are serious and need attention. However, treatment and removal may be delayed until the Priority I patients have been stabilized. These patients do not have severe airway, breathing, circulatory, or mental status problems. Examples may include:
 - Burns
 - Major multiple fractures
 - Spinal injuries
- ❖ **WALKING WOUNDED** (PRIORITY III) (GREEN TAPE): The patients in this category have no apparent injuries as described above, they may have treatment delayed and are generally transported by some other means other than ambulance. Examples may include:
 - Minor fractures
 - Lacerations with minimal blood loss
 - Chest injuries without breathing difficulties
 - Minor burns

- ❖ **D.O.A./NON-RESUSCITABLE** (PRIORITY IV) (BLACK TAPE): These patients are dead or so severely injured that death is certain within a short time, regardless of treatment given. Examples may include:
 - Traumatic cardiac arrest
 - Massive head injuries with brain matter exposed
 - Massive body mutilation or decapitation

- ❖ [REDACTED] (BLUE TAPE): These patients will be triaged according to the START system based upon their injuries. In addition, a blue surveyor's tape will be added to indicate that decontamination of the individual has taken place. Patients involved in a *HazMat* situation will not be moved into treatment areas without the determination of appropriate decontamination. The specific decontamination method used should be listed on the Treatment Tag.

Appendix B

Mass Fatality

Emergency Response Plan (MFERP)

INTRODUCTION

- A mass fatality incident is defined as an occurrence of multiple deaths that overwhelms the capability of local agencies to respond.
- Mass Fatalities Plans. The Office of the Medical Examiner (OME) maintains protocols and Standard Operating Procedures for the processing of human remains resulting from a Mass Fatalities Incident. Appendix B to the Mass Casualty Incident Plan outlines responsibilities and procedures required to manage an incident where many deaths occur thus overwhelming the ability of local agencies to respond.

RESPONSIBILITIES

- A. The National Incident Management System (NIMS) has proven to be the best overall plan of response to a mass fatalities incident. The Chief Medical Examiner, or designee, is an integral part of a unified command. NIMS provides for an integrated response with supporting operations, planning, logistics, and finance sections that are required to handle:
 - a) Search for and Recovery of human remains resulting from disasters.
 - b) Security of the disaster scene and the preservation of evidence.
 - c) Morgue sites and the identification of remains.
 - d) Documentation of the disaster scene and the reconstruction of the incident.
 - e) Resource Planning (before, during and after).
 - f) Locating technical specialists, equipment, supplies, communication, food and shelter for the emergency responders.
 - g) A Family Assistance Center is planned to provide care for the families of the victims to afford them access to counseling, temporary food and shelter, privacy and to solicit information which may be helpful in identifying deceased persons.
- B. The Office of the Medical Examiner has jurisdiction over disaster scenes involving mass fatalities. Subordinate state, county, and city agencies should fully cooperate with the Office of the Medical Examiner to ensure that critical information and evidence is not lost.

OPERATIONS

- A. Major Operations include the following activities:
 - I. Disaster Scene: This scene is the first place the OME will become involved. It is where the recovery of human remains, and the documentation and reconstruction of the disaster occurs. Once efforts to rescue the living have been completed, the process of recovery will begin. Additional manpower and equipment support must be identified and quickly provided so as to not impede an efficient recovery operation.

- a) Body Recovery Teams consist of the following members:
- i. Chief Medical Examiner Investigator
 - ii. Medical Examiner Assistant
 - iii. Scribe/Narrator for documentation of disaster scene
 - iv. Photographer
2. Examination Center: It's important to identify personnel and equipment in advance of the disaster that will be responsible for body identification and processing. When the disaster occurs, preassigned teams must be deployed immediately. Detailed records are to be maintained to track personnel and equipment use, source of procurement, team member's names, agencies represented, hours worked and duties performed. Teams must be merged into the appropriate sections of the Incident Command System to allow proper supervision and support. Details and assignments for the examination center operations include:
- a. Security - ID badges, vests or distinctive markings will be used to preclude non-authorized access to the disaster scene or temporary morgue sites. A system of credentialing must be determined in advance and periodically changed to preserve evidence at the disaster scene.
 - b. Refrigerated trucks or vans will likely be needed for the storage of victim remains or fragmented body parts. Ensure that ramps are available for entrance into cargo areas. Mutual aid agreements must be drafted and possible sources for reefer trailers identified before the disaster occurs.
 - c. Protective clothing such as waterproof and surgical gloves, eye splash shields, scrubs, shoe covers, N-95 masks, coveralls and hard hats must be available for all disaster workers. Chemical/biological agent-resistant personal protective equipment should be available for personnel that must enter contaminated environments. Those tasked with donning protective equipment must be properly screened, trained and qualified prior to the incident. Make provisions to check vital signs and stay times for all responders entering a contaminated area. Ensure that OSHA two-in/two-out requirements are observed at all times.
 - d. Communication - Capabilities must include telephones, cell phones, and PA systems. VHF/UHF radios may be considered for use in the event of the loss of telephone service. Amateur radio operators are also an excellent resource that should not be overlooked.
 - e. Automation - Internet, laptop computers, with modems and email capabilities, and printers are invaluable tools if electrical or battery power is available. An automation specialist should be available to assist with data processing problems.

- f. Post and ante mortem records must be maintained. Place someone in charge to systematically file and distribute critical records. Ante-mortem information must be entered into a database for quick retrieval to identify human remains.
 - g. Office equipment should include copiers, computers, tablets, and an assortment of supplies (pens, paper, etc.).
3. Temporary Morgue Sites: A suitable site may be determined for the temporary storage and assembling of human remains. Adequate space must be available to accommodate the bodies or body parts in a dignified and orderly manner. Bodies will be laid in rows, with aisles, to allow easy access and transporting. A minimum of 20 square feet of space is required for each body. Other considerations include:
- a. Adequate lighting in the work area to permit safe, efficient operation.
 - b. Temperature control for the comfort of the workers and to prevent accelerated decomposition or freezing of the bodies or fragments. The optimal temperature for the storage of human remains is 37 to 42 degrees Fahrenheit. Human remains must be quickly relocated from the temporary site and into refrigerated trucks or to the state morgue
 - c. Although autopsies may not be performed at the temporary morgue, washing of bodies or decontaminated may be required. This will require containment of waste water in approved hazmat barrels or storage bladder
 - d. The disposal of contaminated (biohazard) and uncontaminated trash must be considered and a contractor hired to safely remove it.
 - e. Electrical power is required for lighting, heating, and to operate computers, copiers, and other essential equipment.
 - f. Hard-wired telephone lines for communicating from the temporary morgue are preferred over the less secure cell phones or radios that can be monitored by others.

DEBRIEF

Critical Incident Stress Management

Few responders have had the experience of dealing with a mass fatality incident. The resultant sights and smells will cause most to experience feelings of stress and burnout. Trained disaster counselors are available through local and state sources to deal with the mental anguish that will be experienced by those involved. Planning to rotate personnel frequently and allowing decompression time is critical to maintaining mental health.

Appendix C

Active Shooter Response Plan

Active Shooter Response Plan

I. Introduction

Effective response to an Active Shooter event requires effective planning and role reinforcement through training for personnel caught in the event, as well as for leaders and managers coordinating the response to the event. Personnel in the vicinity of an Active Shooter may need to evacuate or shelter in place depending upon circumstances unique to that event. Organization leadership and managers coordinating the response to an active shooter event need to be able to provide effective direction to personnel in the vicinity of the Active Shooter, provide clear situation information to first responders, and inform the public.

This Active Shooter Response Plan is designed to be a supplement to CareFlites Emergency Response Plan (ERP).

II. Purpose

This Active Shooter Response Plan provides instructions and guidance to effectively address the response of CareFlite to an Active Shooter incident. The Active Shooter Response Plan provides guidance for developing and implementing procedures in response to an Active Shooter incident.

III. Preparedness

An Active Shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated place; in most cases, active shooters use firearms and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the shooting and mitigate harm to victims. Because active shooter situations are often over within 10-15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

IV. Command Structure/Response Organization

The Command Structure/Response Organization for an Active Shooter incident should mirror the normal Command Structure, as found in the *General Organization Positions and Responsibilities* section of the Emergency Action Plan.

The diagram below, which depicts the command structure/response organization, is also included in the Emergency Plan.

Command Structure/Response Organization



A. Jurisdiction and Liability

- Law Enforcement has complete authority
- Law Enforcement will be Incident Command

B. Direction, & Control – Roles and Responsibilities

- Refer to Organization Positions and Responsibilities section

V. Pre-Incident Planning

Active shooter incidents often begin and conclude quickly, leaving facility management and security officers little to no time to coordinate response procedures with law enforcement and employees. Facility readiness requires that managers develop and exercise response plans that apply general preparedness and response protocols to specific types of emergencies and facility capabilities (including security resources). Training and exercising the plan is a key to finding experts and facility managers who participated in active shooter exercises, allowing them to identify gaps, correct weaknesses, and validate their plan.

A. Develop Response Plans and Procedures

- Implement a comprehensive Emergency Action Plan that includes incidents beyond an environmental emergency, such as active shooter or suspicious package.

- Review and update CareFlites Emergency Action Plan with assistance from law enforcement and emergency responders.
- Establish communication procedures for employees to report signs, flags, and threats of workplace violence.
- Establish alternative methods of communication with employees during an incident—including emergency notification system, e-mail, phone, cell phone, text message, and loudspeaker announcements.
- Determine how to estimate the impact of an incident on facility operations and communicate that to customers, the public, and law enforcement.
- Communicate with emergency responders to manage facility expectations of response capabilities.

B. Employee Training and Awareness

- Training captures the development of skills and/or understanding through procedurally defined learning activities focused on a specific application. This component combines the types of training and exercises and the types of personnel trained.
- Train all employees on general emergency plans and those designed for specific scenarios.
- Train security personnel in providing guidance to employees in each scenario.

C. Prepare for an Incident

- Management:
 - Learn how to recognize potential workplace violence and suspicious behavior.
 - Identify the location of the nearest exits, emergency call boxes, potential safe harbors, emergency response kits, and decontamination sites.
- Employees:
 - Become familiar with emergency procedures and regularly review checklists or materials provided on emergency procedures.
 - Identify who to call to report an incident and what information to provide about the situation.

D. Exercise Emergency Action Plans Regularly and Repeatedly

- Schedule regular drills, tabletop and functional exercises.
- Assess gaps in plans, exercises and training.

E. Establish a Relationship with Emergency Responders

- Involve emergency services responders from multiple agencies in facility training and exercises.
- Jointly map out incident management procedures and pre-identify a common, secure radio communication channel.
- Invite all emergency services responders to tour your site and provide details about the facility that will help responders to adjust their protocols if necessary.

- Gain a better understanding and awareness of the complexities involved in an integrated response to an incident, including law enforcement procedures and capabilities and the steps to preserving a crime scene.
- Educate law enforcement on the impact of a crime scene on business operations and restoration.

VI. Incident Response Considerations (On site active shooter plan)

Active shooter incidents often begin and conclude quickly, and the incident may be at any location in the organization or facility. This leaves administration no time to coordinate response procedures with law enforcement and employees. The response to a specific incident will depend on the circumstances unique to that incident. However, there are general procedures that apply to all active shooter incidents.

A. Employees:

- Report the incident:
 - If possible, call **911**
- Evacuate if possible
 - Determine an escape route based on where an active shooter may be located.
 - Leave your belongings behind. Keep your hands empty and visible at all times.
 - Help others evacuate, if possible, but do not attempt to move the wounded. Evacuate even if others do not agree to follow.
 - Move quickly to a safe place far from the shooter and take cover. Remain there until police arrive and give instructions.
 - Remain calm. Avoid screaming or yelling as you evacuate.
 - Follow all instructions of law enforcement.
- Shelter if necessary
 - Go to the nearest room or office and lock the door(s). If the door does not lock, wedge the door shut or use heavy furniture to barricade it.
 - Identify an escape route in the event you are directed to evacuate.
 - Close blinds, turn off lights, and cover windows.
 - Silence all noise, including cell phones, radios, and computers.
 - Have one person call 911, if it is safe to do so. Be prepared to answer the dispatcher's questions.
 - If it is not safe to talk, keep the phone on so it can be monitored by the dispatcher.
 - Stay out of sight and take cover behind large, thick items or furniture.
 - Do not open the door until the person can provide an identification badge.
 - Remain under cover until law enforcement advises it is safe to evacuate.
 - Positively verify the identity of law enforcement as an unfamiliar voice may be the shooter attempting to lure victims from a safe place.

- Act, if you must
 - If there is no opportunity for escape or hiding, as a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter.
- Respond Appropriately When Law Enforcement Arrives
 - Remain calm and follow officers' instructions.
 - Raise your hands, spread your fingers, and keep hands visible at all times.
 - Do not run when police enter the vicinity. Drop to the floor, if you are told to do so, or move calmly out of the area or building.
 - Do not make quick moves toward officers or hold on to them for safety.
 - Avoid pointing, screaming, or yelling.
 - Do not stop officers to ask for help or directions. Evacuate the building in the direction the officers arrived while keeping your hands above your head.
 - For your own safety, do not get upset or argue if an officer questions whether you are a shooter or a victim. Do not resist, even if you are handcuffed and searched.

B. Facility Management and Security:

- Control Access and Account for Personnel
 - Do personnel have the ability to remotely lock buildings or deactivate card readers? How does that impact the need to account for employees?
 - How will management notify employees of the situation and its location?
 - How will personnel allow site and building access to emergency responders?
 - Account for full-time, part-time, and contract employees
 - Obtain the visitor log
 - Identify employees and visitors who are onsite
 - Identify employees and visitor locations
- Assist Emergency Responders
 - Use security technology, such as closed-circuit television, to assist law enforcement in locating the victims and shooter(s)
 - Provide site and building maps
 - Provide facility access to emergency responders
 - Ensure critical phone calls get through to security personnel
 - Provide extra radios for emergency responders
 - Ensure incoming emergency response personnel know where to stage
 - Ensure emergency responders are aware of any safety concerns as they enter process areas
- Manage the Perimeter
 - Assist law enforcement in establishing a secure perimeter
 - Control or prevent the entrance of the media

- Establish a media center
 - Establish a safe location to stage evacuees
- Identifying Secondary Impacts
 - Identify additional shooters or other threats
 - Determine if the shooter has knowledge of the facility or its operations
 - If necessary, execute safe shutdown procedures

C. Communication Information

This section outlines the communication equipment, systems, and terminology used at CareFlite for communication among all personnel (i.e., local law enforcement, fire department, Emergency Management Agency, media, facility security, etc.).

- Terminology is defined by NIMS and common terminology is defined in the beginning of CareFlites Emergency Response Plan

D. Activation, Staging, and Mobilization

Refer to CareFlites activation process in the Emergency Response Plan. There should be separate staging areas for emergency responders and evacuees or victims of the active shooter incident. Information should be provided on the preplanned location(s), personnel, equipment (i.e., decontamination, air monitoring), and other resources needed for activating, operating and demobilizing a staging area.

E. Incident Recovery Considerations

- Address Victims and Families
 - Established a family hotline
 - Assist with victim identification
 - Gather information related to victim identities, extent of injuries, and what hospitals are being utilized
 - Notify the family members
 - Use personnel who are specifically trained for this responsibility
 - Procure counselors for employees and families
 - Develop an action plan to handle concerns about returning to work
- Communicate Internally
 - Develop instructions for management to give to employees
 - Develop a plan for communicating the information
 - Consider if employees should return to their homes, remain onsite at a specified location, go to another site, etc.
 - Determine how facility personnel will communicate with families
- Communicate Externally
 - Identify the designated official for responding to media inquiries
 - Determine what information and details facility personnel will provide to the media that will ease community concerns without inciting panic or hindering the investigation

- Continue Business Operations
 - Implement business recovery/continuity plans
 - Make re-entry decisions after site is released by law enforcement
 - Provide safety and security debriefings
 - Fill positions of deceased and injured employees
 - Take actions to ensure employees feel safe
 - Determine how the facility will continue operating with limited production or with certain areas of the facility designated a crime scene

VII. Post Incident Review/After Action Review Process

This section provides an overview of the After Action Review (AAR) Process. An AAR should be conducted immediately following an exercise or event and should involve representatives from each participating agency. This should include information on the major events, all lessons learned, and review any new initiatives developed or identified during the exercise or event. The AAR should also include a discussion of all techniques, tactics, and procedures utilized during the exercise/event to include what went right and what went wrong. It should identify any issues and the consequences resulting from the potential outcomes of those issues. Following the AAR meetings and discussion, an After Action Report/Improvement Plan (AAR/IP) should be written which identifies areas that require improvements, the actions required, the timelines for implementing those improvements, and the organization and party responsible for this action. The AAR/IP should be shared with all stakeholders, and used to further define the plans and procedures related to events at the stadium.

VIII. Program and Plan Maintenance

The Active Shooter Response Plan will be maintained, reviewed, and updated following the Emergency Plan's preparedness cycle that includes planning, training, exercising/responding, evaluating and mitigating. All stakeholders should participate in each phase of this cycle to ensure that the plan reflects the current operational strategies, organizational structures, and methodologies utilized by response personnel. Following each event, training, or incident, an evaluation of all response actions and in-place mitigation measures should be performed. This will allow for the identification of areas to be sustained, improved, or added to enhance the organization or facility overall preparedness.

This section provides an overview of how to utilize the preparedness cycle for maintenance of the Active Shooter Response Plan.

A. Program Maintenance

- *List the annual training, exercises, and drill plan.*

B. Plan Maintenance and Revision

- *List the maintenance and revision plans.*

Appendix D

Incident Plan Guidelines for Special Events and Scenarios

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High School Football Game

Prepare

Preparing for a local, low-visibility sporting event such as a high school football game begins with collecting information such as:

- requesting agency, point of contact, and contact information for follow-up;
- financial compensation information, if applicable;
- location of event(s) including intended staging location of ambulance and crew, ingress and egress routes from field;
- contact information for the team's athletic trainer/sports medicine personnel if applicable;
- contact information for any security or event personnel involved; and
- anticipated/historical attendance numbers, issues.

When this information has been obtained, a very brief risk assessment should be performed (if one has not already been done for this type of event). Contact should be made with any other involved medical personnel to coordinate operations:

- Athletic trainers
 - Athletic trainers may be able to assist with injured players.
 - Athletic trainers may be trained in cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED) and are likely to be first on scene if a player collapses.
 - Can assist with removing protective equipment, such as helmets.
- Sports medicine staff
 - Sports medicine staff will be able to assist with injured players.
 - Sports medicine staff should be trained in CPR/AED and are likely to arrive before EMS.
- Security staff
 - Security staff may have CPR/AED training and should know where AEDs are located at the event. Security staff will be helpful in locating or moving ill or injured spectators.
 - Security staff will also be able to help in guiding additional medical resources to the incident.
- Fire department or EMS agency (if different from your own) that has jurisdiction over the location of the event.
 - If your agency does not have jurisdiction, the agency with jurisdiction may choose to respond and assume control of any incident that occurs.

Forms:

- When coordinating planning with other agencies, an ICS Form 201 (Incident Briefing) should be sufficient.
- If ICS forms are going to address other disciplines such as security or logistics, add an ICS Form 206 (Medical Plan).

Respond

Responding to an emergency at any spectator sport will become a high-visibility event. Inevitably, photos, and video of the responding personnel will be available on the internet within minutes of the incident occurring. A Public Information Officer (PIO) should be appointed.

If an event occurs in the stands, parking lot, or other areas, security and other event personnel might not be aware of the emergency. This is where the EMS planning related to collection of contact information will become useful. Communication personnel can use the contact information to notify event staff as well as direct them to acquire an AED or other equipment if applicable.

For incidents involving multiple agencies, a copy of the completed ICS Form 201 can help to orient the Incident Commander (IC) to the area and resources available. Additional ICS forms may be used in the Incident Action Plan (IAP) based on the type and scope of incident.

Recover

Recovery from this type of event should not be overly complex. Recovery will likely be limited to cleaning and restocking equipment according to standard operating procedures (SOPs). In instances involving emotionally charged situations, such as unsuccessful resuscitation of a child, debriefing or Critical Incident Stress Management (CISM) may be indicated. If issues arose during the response or patient treatment that have attracted the attention of conventional or social media, a PIO needs to be appointed for the incident and active management of the situation should begin.

If the incident involves numerous units or lasts several hours, demobilization procedures should be followed and recorded on ICS Form 221 (Demobilization) to ensure that mutual aid and other resources are properly accounted for and returned to service.

Residential Medical Facility Evacuation

Prepare

Preparations for evacuation of a residential medical facility such as a nursing home or senior-citizen center should be taken very seriously. Any large evacuation of a vulnerable population such as this is likely to result in some injuries or exacerbated illness. Responders are at increased risk of injuries due to repetitive lifting in a high-stress situation. Residents are at risk of being injured during moves. The extra activity and stress of an evacuation may result in respiratory, cardiovascular, or other medical complications.

A risk assessment should be performed for your community to determine which facilities are at highest risk for evacuation. This would include facilities vulnerable to wildfire, earthquake, flooding and other weather-related threats. A majority of planning resources should be devoted to these facilities, although evacuation due to fire or utility failure can occur anywhere. Evacuation planning should be conducted in coordination with numerous agencies and individuals:

- Decisionmakers from the involved facility.
 - Background information such as average census, location of the most vulnerable residents, etc.
 - Information on what type of evacuation equipment might be available, such as stair chairs, evacuation mattresses, and where it is stored or obtained in an emergency.
 - Responsible for securing receiving facilities for residents during a precautionary evacuation.
 - Responsible for providing training to their staff on the evacuation procedures.
 - Copies of the facility floor plan outlining exits and locations of emergency equipment.
- Fire department and police department.
 - Fire department may provide additional personnel even if no immediate life-threats exist.
 - Police department may assist with controlling traffic or provide additional personnel.
- Emergency management.
 - Will likely provide the information that triggers decision makers at the involved facility to begin a precautionary evacuation.
 - In some situations, officials may order a mandatory evacuation.
 - Able to coordinate resources to assist with the evacuation.
- Public health department.
 - May be able to assist in coordination process.
 - May have access to medical assets such as Medical Reserve Corps or Metropolitan Medical Response System.
- Mutual aid partners.
 - Verify that your mutual aid partners will honor a request for aid if it involves a precautionary evacuation, with no immediate emergency.

- Area EMS agencies.
 - Determine type and number of resources that are likely to be available from each agency.
 - Estimate time to respond based on location of base of operations.
- Transportation services.
 - Wheelchair van services.
 - School buses.
 - Public buses.
 - AMBUS

Forms:

- ICS Form 201 could be used to document planning for a facility evacuation, or a custom operations template might be used.
- ICS Form 202 (Incident Objective),
- 203 (Organization Assignment List),
- 204 (Assignment List),
- 205 (Incident Radio Communications Plan),
- 206 (Medical Plan) as part of the IAP.
- ICS Form 215a (Incident Action Plan Safety and Risk Analysis) could be used to document specific hazards within the building such as hazardous chemicals or bulk oxygen storage.

Respond

When requested to respond to a residential medical facility evacuation, it is important to clearly define roles and responsibilities. Typically, facility staff are responsible for all activities within the facility such as obtaining admission for the residents at another facility and determining which patients should be transported first.

Similarly, the EMS service with jurisdiction in the area typically is responsible for residents once they exit the facility. This includes organizing the loading of buses, ambulances, and other forms of transportation. However, in a precautionary evacuation situation, facility staff may take on responsibility for organizing all transports if they have sufficient staff and resources. Regardless of how the incident is organized, EMS personnel must work very closely with facility staff to ensure that each resident is transported safely to the appropriate destination.

Additional complexities will be involved in an emergency evacuation. An emergency evacuation will likely be very personnel intensive and physically demanding, especially in a facility with no or limited elevator availability. Evacuations involving stairways are especially demanding and will require more personnel than evacuations at a single-level facility. A facility evacuation will likely attract the attention of media and will involve concerned family members. Therefore, appointing a PIO is important.

Recover

Recovery from a facility evacuation may take many days. It is important for reimbursement purposes that EMS personnel keep excellent records of every transport they provide and any costs associated with the incident. Transportation must be arranged for each resident back to the facility if the building is determined to be safe to occupy. If the facility suffered sufficient damage, the residents may need to be relocated to more permanent facilities while awaiting repair of their home.

Marathon or Similar Running Events

Road races such as marathons, half marathons, and shorter events often occur over a very large road course. Although fixed aid stations may be required, means of responding to incidents on the course are also necessary. Caution must be exercised during response to avoid injury to participants or spectators while attempting to respond alongside the runners or attempting to cross a closed course.

Please note that runners in a crowd may not notice an ambulance attempting to cross the course due to the other runners in front of them blocking their vision and the loud background noises from cheering spectators blocking their ability to hear warning devices.

A simple risk assessment should be performed (if not already performed for this type of event) to determine the likely emergencies responders will encounter.

Prepare

- Event sponsor:
 - Determine exact route of course, including road closures and potential emergency crossing points.
 - Determine expected attendance for both participants and spectators. (Participants are much more likely than spectators to request assistance during the event).
 - Determine number and capabilities of medical aid stations for the event. EMS personnel may or may not be involved in staffing/operating the aid stations.
 - Determine the number and type of EMS resources needed.
 - Determine number and qualifications of aid station personnel needed.
- Law enforcement:
 - Coordinate ambulance ingress and egress routes to ensure timely responses and participant and spectator safety.
 - Frequent requestors of medical aid on behalf of spectators or participants. Officers should be provided instructions on what information dispatch requires in order to determine the patient's priority.
- Aid station staff (if different agency providing):

Coordinate ambulance ingress and egress.

- Discuss parameters by which patients will be treated at the aid station, and who will be transported to a hospital.
 - Discuss how to handle moving participants from the course to the aid station.
 - Determine whether EMS will be responsible for providing any supplies to the aid station.
-
- Representative from local hospitals:
 - Provide information to local hospitals so they can make informed staffing decisions for the day of the race.
 - Mutual aid partners, local EMS agencies:

- Attempt to determine how many additional resources mutual aid partners and local EMS agencies may be able to send in case of a mass care incident.
- Make sure mutual aid partners are aware of the race and how it will affect traffic/road closures.
- Events such as these often-cross multiple jurisdictions, event planning should incorporate representatives from each jurisdiction, and Unified Command (UC) will likely be necessary

Forms:

- ICS Form 201,
- 202,
- 203,
- 205,
- 206,
- 214 (Unit Log)

Respond

Units responding to this type of event may be requested to stage a short distance away from the patient while event personnel package and move the patient to the waiting ambulance by stretcher or specialty golf-cart style vehicles. It is critical that all ambulances responding to an event such as this are provided with SOPs guiding whether or not they are permitted to transport patients to the medical aid station.

Recover

Recovery from any mass casualty incident (MCI) is likely to generate a media response, but media will likely already be on site due to their coverage of the event. Assigning a PIO early will help to manage this. If any of the medical aid stations become involved in providing care during a mass casualty situation, it is likely that some mixing of equipment and supplies may occur that needs to be addressed to return units to service.

Weather-Related Disaster Declaration

Disaster declarations caused by weather events such as hurricanes, flooding, tornados, or snow and ice storms require a few unique planning considerations. Weather events frequently affect your mutual aid partners in the same way that your jurisdiction is being affected. Therefore, mutual aid assets that might be available during a mass casualty situation may no longer be available or may not be able to respond to specific areas due to road conditions. This requires EMS services to ensure they have sufficient surge capacity to deal with likely occurrences in their area of operation.

Prepositioning of supplies, personnel, and other resources may be necessary to avoid response interruptions to areas that may be cut off by rising floodwaters, deep snow, or other weather-related barriers. Careful coordination between adjacent municipalities will help to ensure resources are used efficiently.

An in-depth risk assessment is critical to planning for these types of events. This risk assessment will require coordination with area Emergency Management officials.

Prepare

Planning for such an extensive event may require coordination with:

- Emergency Management officials.
 - Conduit to political leaders.
 - Coordinate professional risk assessments.
 - Establish an Emergency Operations Center (EOC) during the event.
- Fire department and law enforcement agencies within jurisdiction.
 - Ambulances may be stationed at fire stations or police stations to aid in coordination and provide for crew safety.
- Volunteer organizations such as American Red Cross, Salvation Army, etc.
 - Feeding and sheltering of displaced residents likely to be accomplished by one of these two groups.
 - EMS crews are often approached about how to find these shelters so they must have current contact information and location of each shelter.
- Emergency Management Assistance Compact (EMAC).
 - If facility evacuations or other medical transportation issues exceed the capabilities of State resources, State officials will use EMAC agreements to request additional resources from other States.
- Off-road vehicle clubs.
 - With careful management, volunteers with off-road capable vehicles may be useful for assisting in transporting emergency personnel to scenes inaccessible to conventional response vehicles.

- Volunteers may be able to assist emergency responders that become stuck in snow or mud.
- Volunteers may be able to move equipment or personnel from site to site.

Forms:

- ICS Forms 201,
- 202,
- 214
- 215a

Respond

During a weather-related disaster declaration, typical responses become more difficult and time consuming. Therefore, prioritization of requests becomes critical. It is important that public safety answering points be capable of providing medical instructions to callers.

A mass casualty situation during a weather-related disaster will be very challenging for the first EMS unit on scene. Depending on road conditions, a single EMS unit may need to care for many patients for a significant period of time while awaiting additional units. As with all MCIs, media attention and concerned family members are very likely. Therefore, a PIO should be appointed.

Recover

Recovery from an event such as this depends primarily on the damage caused. Recovery may be as simple as normal cleaning and restocking of units, or it may take months or years for a community to fully recover when critical infrastructure is damaged or destroyed.

Careful tracking of expenses is necessary for an EMS agency to have any possibility of receiving disaster assistance funds.

Large College/Pro Sporting Event

Large college sporting events are similar to smaller sporting events, with an added layer of complexity and visibility. Most of the same considerations apply, with a few additions.

Prepare

Preparing for a large college sporting event such as a football or basketball game begins with collecting information such as:

- requesting agency, point of contact, and contact information for follow-up;
- financial compensation information if applicable;
- location of event(s) including intended staging location of ambulance and crew, ingress and egress routes from event;
- contact information for the team's athletic trainer/sports medicine personnel;
- contact information for any security or event personnel involved; and
- anticipated/historical attendance numbers, issues.

When this information has been obtained, a risk assessment should be performed (if one has not already been done for this type of event). Contact should be made with any other involved medical personnel to coordinate operations:

- Athletic trainers.
 - Athletic trainers may be able to assist with injured players.
 - Athletic trainers may be trained in CPR/AED and are likely to be first on scene if a player collapses.
- Sports medicine staff.
 - Sports medicine staff will be able to assist with injured players.
 - Sports medicine staff should be trained in CPR/AED and are likely to arrive before EMS.
- Security staff.
 - Security staff may have CPR/AED training and should know where AEDs are located at the event. Security staff will be helpful in locating or moving ill or injured spectators.
 - Security staff will also be able to help in guiding additional medical resources to the incident.
- Fire department or EMS agency (if different from CareFlite) that has jurisdiction over the location of the event.
 - If CareFlite does not have jurisdiction, the agency with jurisdiction may choose to respond and assume control of any incident that occurs.

Forms:

- ICS Forms 202,
- 204,
- 205,
- 206 will likely be needed during planning for an event such as this.
- ICS Forms 207 (Incident Organization Chart)

- 214 may be required
- 221 This form may be needed if mutual aid is used

Respond

Responding to an emergency at any spectator sport will become a high-visibility event. Inevitably, photos and video of the responding personnel will be available on the internet within minutes of the incident occurring. If an event occurs in the stands, parking lot, or other areas, security and other event personnel might not be aware of the emergency. This is where the EMS planning related to collection of contact information will become useful.

Communication personnel can use the contact information to notify event staff as well as direct them to acquire an AED or other equipment if applicable.

If issues arise during the response or patient treatment that have attracted the attention of conventional or social media, a PIO needs to be appointed for the incident and active management of the situation should begin.

Recover

Recovery from this type of event should not be overly complex. Recovery will likely be limited to cleaning and restocking equipment according to SOPs. In instances involving emotionally charged situations, such as unsuccessful resuscitation of a child, debriefing or CISM may be indicated.

If the incident involved numerous units or lasted several hours, demobilization procedures should be followed and recorded on ICS Form 221 to ensure that mutual aid and other resources are properly accounted for and returned to service

Auto Racing/Competition

Automobile racing and other forms of automotive competition often involve very high speeds and significant potential for injury to competitors and spectators alike. Some modern speedways are designed to prevent out of control vehicles from endangering spectators, but even at these venues, there are numerous pit crew and other event personnel that are not fully protected by these barricades. Therefore, the potential for mass casualties with very significant injuries exists. Automobile competition encompasses a wide range of different events and vehicles. From high speed NASCAR events to low speed but high-energy truck pulls to off road racing, each type of event offers unique challenges to EMS planners

Prepare

As with all planning, gather critical background information:

- point of contact with event personnel;
- point of contact with event security personnel;
- expected attendance;
- details about safety equipment unique to event vehicles such as helmets, fuel and electrical cut-offs, or HANS (Head and Neck Support) system devices;
- details about course access procedures, ingress and egress routes; and
- details about medical aid stations, if applicable

When this information has been obtained, a very brief risk assessment should be performed (if one has not already been done for this type of event). Contact should be made with any other involved personnel to coordinate operations:

- Medical aid station personnel (if not from your service).
 - Coordinate staffing and stocking of medical supplies and equipment.
- Rescue technicians responsible for extrication of drivers from vehicles.
 - Coordinate precisely where areas of responsibility lie, such as provision of cervical immobilization equipment or other medical equipment.
- Fire suppression personnel.
 - Coordinate who is responsible for clearing EMS personnel to approach after a crash.
 - Define hot, warm, and cold zones during extrication process.
- Any other medical personnel involved.
 - Course/Event physicians.
 - Helicopter pilots and personnel.
- Off-road vehicle clubs.
 - For off-road vehicle races, access to the course can be extremely difficult. Off-road clubs may be able to provide drivers and vehicles to transport EMS personnel out onto the course.

Forms:

ICS Form 206

ICS Form 214 During the event, this form may be requested from medical personnel

ICS Form 221

Respond

CareFlite personnel must exercise extreme caution when operating on or near vehicle race tracks. Defined safety procedures must be followed to ensure that drivers on the course are notified and reduce speed prior to any personnel attempting to enter the area. CareFlite personnel must follow direction from course officials on when to ingress or egress an area. Failure to follow directions could result in injuries not only to CareFlite personnel but also could result in crashes and other injuries.

A mass casualty situation during this type of event could involve numerous hazards and significant mechanism of injury. Careful coordination between involved agencies will be necessary to effectively manage this type of event.

ICS Form 206 is likely the only ICS Form that EMS personnel may be responsible for during this type of event. During the event, ICS Form 214 may be requested from medical personnel. Use caution when completing this form as it should not include any Health Insurance Portability and Accountability Act (HIPAA) protected information.

Recover

No unique recovery actions are likely. Due to media coverage, EMS public relations staff may wish to become involved. Protracted or complicated events may require the use of ICS Form 221.

Sample EMS Event Specific Operations Plan

Event Background

The Cowtown Marathon will take place on September 29, 2022. The event actually includes the following races: the Shriners 8k Race, Whole Foods Half Marathon, and the 1st National Townville Marathon.

Duration: The first race (8k) will begin at 0700, the half marathon will begin at 0730, and the full marathon will begin at 0800. Projected completion time is 1500 hours. Runners are limited to a 7-hour maximum.

Course: The course is a 26.2-mile race, covering most of the city. The start line is at 12th and Broad, and the finish line is at 1st and Main.

Expected Attendance: There are 15,000 people registered as participants, and 20,000 spectators are possible.

Weather Forecast: It is predicted to be partly cloudy, high of 68 °F, low of 36 °F with a 20 percent chance of precipitation (as of 9-20-11).

Sponsoring Organization: The organization sponsoring the event is the Fort Worth CATS, located at 123 Main Street, Fort Worth, Tx 76040. Their main phone number is 313-123-4567.

Potential Impact

The most significant impact will be on EMS at the event itself. There are 15,000 potential participants of widely varying levels of fitness competing in a 5.0, 13.1, and 26.2-mile running race, combined with 5,000 possible spectators. Based on last year's event data, 0.8 percent of all participants sought medical attention. If this ratio holds true this year, onsite medical services could experience 123 or more medical requests and 9 EMS transports from the event.

EMS operations outside of the actual event will also be impacted. Travel throughout the city will be impeded for 7 hours or more during the busiest part of the day. Communication officers and field units alike must plan for this and route accordingly.

Contacts

List pertinent contacts for that particular event

Include their position and their phone number in case they need to be contacted during the event.

Resource Listing

List all resources that are physically at the event.

List any Aid stations and where they are located

- List the capabilities of each aid station
 - (first aid, hydration and cooling, etc)

List any ambulances on standby and where they are located

- Include ingress and egress for any transport units that would respond to the event

Communications

A list of all radio channels being used at the event should be listed

For calls received by 9-1-1 line from the event:

For calls received by the communications center via 9-1-1, the call taker will take the call in accordance with normal IAED procedures. After the call is received, the communications center will advise field communications of the location, nature, and priority of the incident. **After field communications acknowledges receipt of the call, the communications center will cancel the call for computer-aided design (CAD) purposes.** Field communications will then dispatch the closest available standby unit to respond to the incident. If a transport unit is required, field communications will then advise the communications center of an evacuation point for the system ambulance to respond to.

Appendix E

NIMS ICS Forms



National Incident
Management System
Incident Command
System
September 2010



**NATIONAL INCIDENT MANAGEMENT
SYSTEM INCIDENT COMMAND SYSTEM**

**ICS FORMS BOOKLET
FEMA 502-2**

September 2010

INTRODUCTION TO ICS FORMS

The National Incident Management System (NIMS) Incident Command System (ICS) Forms Booklet, FEMA 502-2, is designed to assist emergency response personnel in the use of ICS and corresponding documentation during incident operations. This booklet is a companion document to the NIMS ICS Field Operations Guide (FOG), FEMA 502-1, which provides general guidance to emergency responders on implementing ICS. This booklet is meant to complement existing incident management programs and does not replace relevant emergency operations plans, laws, and ordinances. These forms are designed for use within the Incident Command System, and are not targeted for use in Area Command or in multiagency coordination systems.

These forms are intended for use as tools for the creation of Incident Action Plans (IAPs), for other incident management activities, and for support and documentation of ICS activities. Personnel using the forms should have a basic understanding of NIMS, including ICS, through training and/or experience to ensure they can effectively use and understand these forms. These ICS Forms represent an all-hazards approach and update to previously used ICS Forms. While the layout and specific blocks may have been updated, the functionality of the forms remains the same. It is recommended that all users familiarize themselves with the updated forms and instructions.

A general description of each ICS Form's purpose, suggested preparation, and distribution are included immediately after the form, including block-by-block completion instructions to ensure maximum clarity on specifics, or for those personnel who may be unfamiliar with the forms.

The ICS organizational charts contained in these forms are examples of how an ICS organization is typically developed for incident response. However, the flexibility and scalability of ICS allow modifications, as needed, based on experience and particular incident requirements.

These forms are designed to include the essential data elements for the ICS process they address. The use of these standardized ICS Forms is encouraged to promote consistency in the management and documentation of incidents in the spirit of NIMS, and to facilitate effective use of mutual aid. In many cases, additional pages can be added to the existing ICS Forms when needed, and several forms are set up with this specific provision. The section after the ICS Forms List provides details on adding appendixes or fields to the forms for jurisdiction- or discipline-specific needs.

It may be appropriate to compile and maintain other NIMS-related forms with these ICS Forms, such as resource management and/or ordering forms that are used to support incidents. Examples of these include the following Emergency Management Assistance Compact (EMAC) forms: REQ-A (Interstate Mutual Aid Request), Reimbursement Form R-1 (Interstate Reimbursement Form), and Reimbursement Form R-2 (Intrastate Reimbursement Form).

ICS FORMS LIST

This table lists all of the ICS Forms included in this publication.

Notes:

- In the following table, the ICS Forms identified with an asterisk (*) are typically included in an IAP.
- Forms identified with two asterisks (**) are additional forms that could be used in the IAP.
- The other ICS Forms are used in the ICS process for incident management activities, but are not typically included in the IAP.
- The date and time entered in the form blocks should be determined by the Incident Commander or Unified Command. Local time is typically used.

ICS Form #	Form Title	Typically Prepared by:
ICS 201	Incident Briefing	Initial Incident Commander
*ICS 202	Incident Objectives	Planning Section Chief
*ICS 203	Organization Assignment List	Resources Unit Leader
*ICS 204	Assignment List	Resources Unit Leader and Operations Section Chief
*ICS 205	Incident Radio Communications Plan	Communications Unit Leader
**ICS 205A	Communications List	Communications Unit Leader
*ICS 206	Medical Plan	Medical Unit Leader (reviewed by Safety Officer)
ICS 207	Incident Organization Chart <i>(wall-mount size optional 8½" x 14")</i>	Resources Unit Leader
**ICS 208	Safety Message/Plan	Safety Officer
ICS 209	Incident Status Summary	Situation Unit Leader
ICS 210	Resource Status Change	Communications Unit Leader
ICS 211	Incident Check-In List <i>(optional 8½" x 14" and 11" x 17")</i>	Resources Unit/Check-In Recorder
ICS 213	General Message <i>(3-part form)</i>	Any Message Originator
ICS 214	Activity Log <i>(optional 2-sided form)</i>	All Sections and Units
ICS 215	Operational Planning Worksheet <i>(optional 8½" x 14" and 11" x 17")</i>	Operations Section Chief
ICS 215A	Incident Action Plan Safety Analysis	Safety Officer
ICS 218	Support Vehicle/Equipment Inventory <i>(optional 8½" x 14" and 11" x 17")</i>	Ground Support Unit
ICS 219-1 to ICS 219-8, ICS 219-10 <i>(Cards)</i>	Resource Status Card (T-Card) <i>(may be printed on cardstock)</i>	Resources Unit
ICS 220	Air Operations Summary Worksheet	Operations Section Chief or Air Branch Director
ICS 221	Demobilization Check-Out	Demobilization Unit Leader
ICS 225	Incident Personnel Performance Rating	Supervisor at the Incident

ICS FORM ADAPTION, EXTENSION, AND APPENDIXES

The ICS Forms in this booklet are designed to serve all-hazards, cross-discipline needs for incident management across the Nation. These forms include the essential data elements for the ICS process they address, and create a foundation within ICS for complex incident management activities. However, the flexibility and scalability of NIMS should allow for needs outside this foundation, so the following are possible mechanisms to add to, extend, or adapt ICS Forms when needed.

Because the goal of NIMS is to have a consistent nationwide approach to incident management, jurisdictions and disciplines are encouraged to use the ICS Forms as they are presented here—unless these forms do not meet an organization's particular incident management needs for some unique reason. If changes are needed, the focus on essential information elements should remain, and as such the spirit and intent of particular fields or "information elements" on the ICS Forms should remain intact to maintain consistency if the forms are altered. Modifications should be clearly indicated as deviations from or additions to the ICS Forms. The following approaches may be used to meet any unique needs.

ICS Form Adaptation

When agencies and organizations require specialized forms or information for particular kinds of incidents, events, or disciplines, it may be beneficial to utilize the essential data elements from a particular ICS Form to create a more localized or field-specific form. When this occurs, organizations are encouraged to use the relevant essential data elements and ICS Form number, but to clarify that the altered form is a specific organizational adaptation of the form. For example, an altered form should clearly indicate in the title that it has been changed to meet a specific need, such as "ICS 215A, Hazard Risk Analysis Worksheet, Adapted for Story County Hazmat Program."

Extending ICS Form Fields

Particular fields on an ICS Form may need to include further breakouts or additional related elements. If such additions are needed, the form itself should be clearly labeled as an adapted form (see above), and the additional sub-field numbers should be clearly labeled as unique to the adapted form. Letters or other indicators may be used to label the new sub-fields (if the block does not already include sub-fields).

Examples of possible field additions are shown below for the ICS 209:

- Block 2: Incident Number
 - Block 2A (adapted): Full agency accounting cost charge number for primary authority having jurisdiction.
- Block 29: Primary Materials or Hazards Involved (hazardous chemicals, fuel types, infectious agents, radiation, etc.)
 - Block 29A (adapted): Indicate specific wildland fire fuel model number.

Creating ICS Form Appendixes

Certain ICS Forms may require appendixes to include additional information elements needed by a particular jurisdiction or discipline. When an appendix is needed for a given form, it is expected that the jurisdiction or discipline will determine standardized fields for such an appendix and make the form available as needed.

Any ICS Form appendixes should be clearly labeled with the form name and an indicator that it is a discipline- or jurisdiction-specific appendix. Appendix field numbering should begin following the last identified block in the corresponding ICS Form.

6. Prepared by: Name: _____ Position/Title: _____ Signature: _____	
ICS 201, Page 1	Date/Time: _____

6. Prepared by: Name: _____	Position/Title: _____	Signature: _____
ICS 201, Page 2	Date/Time: _____	

INCIDENT BRIEFING (ICS 201)

1. Incident Name:	2. Incident Number:	3. Date/Time Initiated: Date: _____ Time: _____
9. Current Organization (fill in additional organization as appropriate):		
<pre>graph TD; IC[Incident Commander(s)] --- LO[Liaison Officer]; IC --- SO[Safety Officer]; IC --- PIO[Public Information Officer]; IC --- OSC[Operations Section Chief]; IC --- PSC[Planning Section Chief]; IC --- LSC[Logistics Section Chief]; IC --- FASC[Finance/Admin Section Chief];</pre>		

6. Prepared by: Name: _____	Position/Title: _____	Signature: _____
ICS 201, Page 3	Date/Time: _____	

**ICS 201
Incident Briefing**

Purpose. The Incident Briefing (ICS 201) provides the Incident Commander (and the Command and General Staffs) with basic information regarding the incident situation and the resources allocated to the incident. In addition to a briefing document, the ICS 201 also serves as an initial action worksheet. It serves as a permanent record of the initial response to the incident.

Preparation. The briefing form is prepared by the Incident Commander for presentation to the incoming Incident Commander along with a more detailed oral briefing.

Distribution. Ideally, the ICS 201 is duplicated and distributed before the initial briefing of the Command and General Staffs or other responders as appropriate. The "Map/Sketch" and "Current and Planned Actions, Strategies, and Tactics" sections (pages 1–2) of the briefing form are given to the Situation Unit, while the "Current Organization" and "Resource Summary" sections (pages 3–4) are given to the Resources Unit.

Notes:

- The ICS 201 can serve as part of the initial Incident Action Plan (IAP).
- If additional pages are needed for any form page, use a blank ICS 201 and repage as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Incident Number	Enter the number assigned to the incident.
3	Date/Time Initiated • Date, Time	Enter date initiated (month/day/year) and time initiated (using the 24-hour clock).
4	Map/Sketch (include sketch showing the total area of operations, the incident site/area, impacted and threatened areas, overflight results, trajectories, impacted shorelines, or other graphics depicting situational status and resource assignment)	Show perimeter and other graphics depicting situational status, resource assignments, incident facilities, and other special information on a map/sketch or with attached maps. Utilize commonly accepted ICS map symbology. If specific geospatial reference points are needed about the incident's location or area outside the ICS organization at the incident, that information should be submitted on the Incident Status Summary (ICS 209). North should be at the top of page unless noted otherwise.
5	Situation Summary and Health and Safety Briefing (for briefings or transfer of command) Recognize potential incident Health and Safety Hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards.	Self-explanatory
6	Prepared by • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

7	Current and Planned Objectives	Enter the objectives used on the incident and note any specific problem areas.
----------	---------------------------------------	--

Block Number	Block Title	Instructions
8	Current and Planned Actions, Strategies, and Tactics <ul style="list-style-type: none"> • Time • Actions 	Enter the current and planned actions, strategies, and tactics and time they may or did occur to attain the objectives. If additional pages are needed, use a blank sheet or another ICS 201 (Page 2), and adjust page numbers accordingly.
9	Current Organization (fill in additional organization as appropriate) <ul style="list-style-type: none"> • Incident Commander(s) • Liaison Officer • Safety Officer • Public Information Officer • Planning Section Chief • Operations Section Chief • Finance/Administration Section Chief • Logistics Section Chief 	<ul style="list-style-type: none"> • Enter on the organization chart the names of the individuals assigned to each position. • Modify the chart as necessary, and add any lines/spaces needed for Command Staff Assistants, Agency Representatives, and the organization of each of the General Staff Sections. • If Unified Command is being used, split the Incident Commander box. • Indicate agency for each of the Incident Commanders listed if Unified Command is being used.
10	Resource Summary	Enter the following information about the resources allocated to the incident. If additional pages are needed, use a blank sheet or another ICS 201 (Page 4), and adjust page numbers accordingly.
	• Resource	Enter the number and appropriate category, kind, or type of resource ordered.
	• Resource Identifier	Enter the relevant agency designator and/or resource designator (if any).
	• Date/Time Ordered	Enter the date (month/day/year) and time (24-hour clock) the resource was ordered.
	• ETA	Enter the estimated time of arrival (ETA) to the incident (use 24-hour clock).
	• Arrived	Enter an "X" or a checkmark upon arrival to the incident.
	• Notes (location/assignment/status)	Enter notes such as the assigned location of the resource and/or the actual assignment and status.

INCIDENT OBJECTIVES (ICS 202)

1. Incident Name:	2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____															
3. Objective(s): 																
4. Operational Period Command Emphasis: 																
General Situational Awareness 																
5. Site Safety Plan Required? Yes <input type="checkbox"/> No <input type="checkbox"/> Approved Site Safety Plan(s) Located at:																
6. Incident Action Plan (the items checked below are included in this Incident Action Plan): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> ICS 203</td> <td style="width: 33%;"><input type="checkbox"/> ICS 207</td> <td style="width: 33%;"><input type="checkbox"/> Other Attachments: _____</td> </tr> <tr> <td><input type="checkbox"/> ICS 204</td> <td><input type="checkbox"/> ICS 208</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> ICS 205</td> <td><input type="checkbox"/> Map/Chart</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> ICS 205A</td> <td><input type="checkbox"/> Weather Forecast/Tides/Currents</td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td><input type="checkbox"/> ICS 206</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> ICS 203	<input type="checkbox"/> ICS 207	<input type="checkbox"/> Other Attachments: _____	<input type="checkbox"/> ICS 204	<input type="checkbox"/> ICS 208	<input type="checkbox"/> _____	<input type="checkbox"/> ICS 205	<input type="checkbox"/> Map/Chart	<input type="checkbox"/> _____	<input type="checkbox"/> ICS 205A	<input type="checkbox"/> Weather Forecast/Tides/Currents	<input type="checkbox"/> _____	<input type="checkbox"/> ICS 206		
<input type="checkbox"/> ICS 203	<input type="checkbox"/> ICS 207	<input type="checkbox"/> Other Attachments: _____														
<input type="checkbox"/> ICS 204	<input type="checkbox"/> ICS 208	<input type="checkbox"/> _____														
<input type="checkbox"/> ICS 205	<input type="checkbox"/> Map/Chart	<input type="checkbox"/> _____														
<input type="checkbox"/> ICS 205A	<input type="checkbox"/> Weather Forecast/Tides/Currents	<input type="checkbox"/> _____														
<input type="checkbox"/> ICS 206																
7. Prepared by: Name: _____ Position/Title: _____ Signature: _____																

8. Approved by Incident Commander: Name: _____ Signature: _____		
ICS 202	IAP Page _____	Date/Time: _____

**ICS 202
Incident Objectives**

Purpose. The Incident Objectives (ICS 202) describes the basic incident strategy, incident objectives, command emphasis/priorities, and safety considerations for use during the next operational period.

Preparation. The ICS 202 is completed by the Planning Section following each Command and General Staff meeting conducted to prepare the Incident Action Plan (IAP). In case of a Unified Command, one Incident Commander (IC) may approve the ICS 202. If additional IC signatures are used, attach a blank page.

Distribution. The ICS 202 may be reproduced with the IAP and may be part of the IAP and given to all supervisory personnel at the Section, Branch, Division/Group, and Unit levels. All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 202 is part of the IAP and can be used as the opening or cover page.
- If additional pages are needed, use a blank ICS 202 and repage as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident. If needed, an incident number can be added.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Objective(s)	Enter clear, concise statements of the objectives for managing the response. Ideally, these objectives will be listed in priority order. These objectives are for the incident response for this operational period as well as for the duration of the incident. Include alternative and/or specific tactical objectives as applicable. Objectives should follow the SMART model or a similar approach: <u>S</u> pecific – Is the wording precise and unambiguous? <u>M</u> easurable – How will achievements be measured? <u>A</u> ction-oriented – Is an action verb used to describe expected accomplishments? <u>R</u> ealistic – Is the outcome achievable with given available resources? <u>T</u> ime-sensitive – What is the timeframe?
4	Operational Period Command Emphasis	Enter command emphasis for the operational period, which may include tactical priorities or a general weather forecast for the operational period. It may be a sequence of events or order of events to address. This is not a narrative on the objectives, but a discussion about where to place emphasis if there are needs to prioritize based on the Incident Commander's or Unified Command's direction. Examples: Be aware of falling debris, secondary explosions, etc.
	General Situational Awareness	General situational awareness may include a weather forecast, incident conditions, and/or a general safety message. If a safety message is included here, it should be reviewed by the Safety Officer to ensure it is in alignment with the Safety Message/Plan (ICS 205).
5	Site Safety Plan Required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Safety Officer should check whether or not a site safety plan is required for this incident.

	Approved Site Safety Plan(s) Located At	Enter the location of the approved Site Safety Plan(s).
--	--	---

Block Number	Block Title	Instructions
6	Incident Action Plan (the items checked below are included in this Incident Action Plan): <input type="checkbox"/> ICS 203 <input type="checkbox"/> ICS 204 <input type="checkbox"/> ICS 205 <input type="checkbox"/> ICS 205A <input type="checkbox"/> ICS 206 <input type="checkbox"/> ICS 207 <input type="checkbox"/> ICS 208 <input type="checkbox"/> Map/Chart <input type="checkbox"/> Weather Forecast/Tides/Currents <u>Other Attachments:</u>	Check appropriate forms and list other relevant documents that are included in the IAP <input type="checkbox"/> ICS 203 – Organization Assignment List <input type="checkbox"/> ICS 204 – Assignment List <input type="checkbox"/> ICS 205 – Incident Radio Communications Plan <input type="checkbox"/> ICS 205A – Communications List <input type="checkbox"/> ICS 206 – Medical Plan <input type="checkbox"/> ICS 207 – Incident Organization Chart <input type="checkbox"/> ICS 208 – Safety Message/Plan
7	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).
8	Approved by Incident Commander <ul style="list-style-type: none"> • Name • Signature • Date/Time 	In the case of a Unified Command, one IC may approve the ICS 202. If additional IC signatures are used, attach a blank page.

ORGANIZATION ASSIGNMENT LIST (ICS 203)

1. Incident Name:		2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____	
3. Incident Commander(s) and Command Staff:		7. Operations Section:	
IC/UCs		Chief	
		Deputy	
Deputy		Staging Area	
Safety Officer		Branch	
Public Info. Officer		Branch Director	
Liaison Officer		Deputy	
4. Agency/Organization Representatives:		Division/Group	
Agency/Organization	Name	Division/Group	
		Division/Group	
		Division/Group	
		Division/Group	
		Branch	
		Branch Director	
		Deputy	
5. Planning Section:		Division/Group	
Chief		Division/Group	
Deputy		Division/Group	
Resources Unit		Division/Group	
Situation Unit		Division/Group	
Documentation Unit		Branch	
Demobilization Unit		Branch Director	
Technical Specialists		Deputy	
		Division/Group	
		Division/Group	
		Division/Group	
6. Logistics Section:		Division/Group	
Chief		Division/Group	
Deputy		Air Operations Branch	
Support Branch		Air Ops Branch Dir.	
Director			
Supply Unit			
Facilities Unit		8. Finance/Administration Section:	
Ground Support Unit		Chief	
Service Branch		Deputy	
Director		Time Unit	
Communications Unit		Procurement Unit	
Medical Unit		Comp/Claims Unit	
Food Unit		Cost Unit	

9. Prepared by: Name: _____ Position/Title: _____ Signature: _____		
ICS 203	IAP Page _____	Date/Time: _____

ICS 203

Organization Assignment List

Purpose. The Organization Assignment List (ICS 203) provides ICS personnel with information on the units that are currently activated and the names of personnel staffing each position/unit. It is used to complete the Incident Organization Chart (ICS 207) which is posted on the Incident Command Post display. An actual organization will be incident or event-specific. **Not all positions need to be filled.** Some blocks may contain more than one name. The size of the organization is dependent on the magnitude of the incident, and can be expanded or contracted as necessary.

Preparation. The Resources Unit prepares and maintains this list under the direction of the Planning Section Chief. Complete only the blocks for the positions that are being used for the incident. If a trainee is assigned to a position, indicate this with a "T" in parentheses behind the name (e.g., "A. Smith (T)").

Distribution. The ICS 203 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 203 serves as part of the IAP.
- If needed, more than one name can be put in each block by inserting a slash.
- If additional pages are needed, use a blank ICS 203 and renumber as needed.
- ICS allows for organizational flexibility, so the Intelligence/Investigations Function can be embedded in several different places within the organizational structure.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none">• Date and Time From• Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Incident Commander(s) and Command Staff <ul style="list-style-type: none">• IC/UCs• Deputy• Safety Officer• Public Information Officer• Liaison Officer	Enter the names of the Incident Commander(s) and Command Staff Label Assistants to Command Staff as such (for example, "Assistant Safety Officer"). For all individuals, use at least the first initial and last name. For Unified Command, also include agency names.
4	Agency/Organization Representatives <ul style="list-style-type: none">• Agency/Organization• Name	Enter the agency/organization names and the names of their representatives. For all individuals, use at least the first initial and last name.

5	Planning Section <ul style="list-style-type: none"> • Chief • Deputy • Resources Unit • Situation Unit • Documentation Unit • Demobilization Unit • Technical Specialists 	Enter the name of the Planning Section Chief, Deputy, and Unit Leaders after each position title. List Technical Specialists with an indication of specialty. If there is a shift change during the specified operational period, list both names, separated by a slash. For all individuals, use at least the first initial and last name.
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Block Number	Block Title	Instructions
6	Logistics Section <ul style="list-style-type: none"> • Chief • Deputy Support Branch <ul style="list-style-type: none"> • Director • Supply Unit • Facilities Unit • Ground Support Unit Service Branch <ul style="list-style-type: none"> • Director • Communications Unit • Medical Unit • Food Unit 	Enter the name of the Logistics Section Chief, Deputy, Branch Directors, and Unit Leaders after each position title. If there is a shift change during the specified operational period, list both names, separated by a slash. For all individuals, use at least the first initial and last name.
7	Operations Section <ul style="list-style-type: none"> • Chief • Deputy • Staging Area Branch <ul style="list-style-type: none"> • Branch Director • Deputy • Division/Group Air Operations Branch <ul style="list-style-type: none"> • Air Operations Branch Director 	Enter the name of the Operations Section Chief, Deputy, Branch Director(s), Deputies, and personnel staffing each of the listed positions. For Divisions/Groups, enter the Division/Group identifier in the left column and the individual's name in the right column. Branches and Divisions/Groups may be named for functionality or by geography. For Divisions/Groups, indicate Division/Group Supervisor. Use an additional page if more than three Branches are activated. If there is a shift change during the specified operational period, list both names, separated by a slash. For all individuals, use at least the first initial and last name.
8	Finance/Administration Section <ul style="list-style-type: none"> • Chief • Deputy • Time Unit • Procurement Unit • Compensation/Claims Unit • Cost Unit 	Enter the name of the Finance/Administration Section Chief, Deputy, and Unit Leaders after each position title. If there is a shift change during the specified operational period, list both names, separated by a slash. For all individuals, use at least the first initial and last name.
9	Prepared by <ul style="list-style-type: none"> • Name 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

	<ul style="list-style-type: none">• Position/Title• Signature• Date/Time	
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9. Prepared by: Name: _____		Position/Title: _____	Signature: _____
ICS 204	IAP Page _____	Date/Time: _____	

**ICS 204
Assignment List**

Purpose. The Assignment List(s) (ICS 204) informs Division and Group supervisors of incident assignments. Once the Command and General Staffs agree to the assignments, the assignment information is given to the appropriate Divisions and Groups.

Preparation. The ICS 204 is normally prepared by the Resources Unit, using guidance from the Incident Objectives (ICS 202), Operational Planning Worksheet (ICS 215), and the Operations Section Chief. It must be approved by the Incident Commander, but may be reviewed and initialed by the Planning Section Chief and Operations Section Chief as well.

Distribution. The ICS 204 is duplicated and attached to the ICS 202 and given to all recipients as part of the Incident Action Plan (IAP). In some cases, assignments may be communicated via radio/telephone/fax. All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 204 details assignments at Division and Group levels and is part of the IAP.
- Multiple pages/copies can be used if needed.
- If additional pages are needed, use a blank ICS 204 and reprogram as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Branch Division Group Staging Area	This block is for use in a large IAP for reference only. Write the alphanumeric abbreviation for the Branch, Division, Group, and Staging Area (e.g., "Branch 1," "Division D," "Group 1A") in large letters for easy referencing.
4	Operations Personnel <ul style="list-style-type: none"> • Name, Contact Number(s) <ul style="list-style-type: none"> - Operations Section Chief - Branch Director - Division/Group Supervisor 	Enter the name and contact numbers of the Operations Section Chief, applicable Branch Director(s), and Division/Group Supervisor(s).
5	Resources Assigned	Enter the following information about the resources assigned to the Division or Group for this period:
	• Resource Identifier	The identifier is a unique way to identify a resource (e.g., ENG-13, IA-SOC-413). If the resource has been ordered but no identification has been received, use TBD (to be determined).
	• Leader	Enter resource leader's name.
	• # of Persons	Enter total number of persons for the resource assigned, including the leader.
• Contact (e.g., phone, pager, radio, frequency, etc.)	Enter primary means of contacting the leader or contact person (e.g., radio, phone, pager, etc.). Be sure to include the area code when listing a phone number.	

5 (continued)	<ul style="list-style-type: none"> Reporting Location, Special Equipment and Supplies, Remarks, Notes, Information 	Provide special notes or directions specific to this resource. If required, add notes to indicate: (1) specific location/time where the resource should report or be dropped off/picked up; (2) special equipment and supplies that will be used or needed; (3) whether or not the resource received briefings; (4) transportation needs; or (5) other information
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Block Number	Block Title	Instructions
6	Work Assignments	Provide a statement of the tactical objectives to be achieved within the operational period by personnel assigned to this Division or Group.
7	Special Instructions	Enter a statement noting any safety problems, specific precautions to be exercised, dropoff or pickup points, or other important information
8	Communications (radio and/or phone contact numbers needed for this assignment) <ul style="list-style-type: none"> Name/Function Primary Contact: indicate cell, pager, or radio (frequency/system/channel) 	Enter specific communications information (including emergency numbers) for this Branch/Division/Group. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 203). Phone and pager numbers should include the area code and any satellite phone specifics. In light of potential IAP distribution, use sensitivity when including cell phone number. Add a secondary contact (phone number or radio) if needed.
9	Prepared by <ul style="list-style-type: none"> Name Position/Title Signature Date/Time 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

6. Prepared by (Communications Unit Leader): Name: _____ Signature: _____		
ICS 205	IAP Page _____	Date/Time: _____

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**ICS 205
Incident Radio Communications Plan**

Purpose. The Incident Radio Communications Plan (ICS 205) provides information on all radio frequency or trunked radio system talkgroup assignments for each operational period. The plan is a summary of information obtained about available radio frequencies or talkgroups and the assignments of those resources by the Communications Unit Leader for use by incident responders. Information from the Incident Radio Communications Plan on frequency or talkgroup assignments is normally placed on the Assignment List (ICS 204).

Preparation. The ICS 205 is prepared by the Communications Unit Leader and given to the Planning Section Chief for inclusion in the Incident Action Plan.

Distribution. The ICS 205 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). All completed original forms must be given to the Documentation Unit. Information from the ICS 205 is placed on Assignment Lists.

Notes:

- The ICS 205 is used to provide, in one location, information on all radio frequency assignments (down to the Division/Group level) for each operational period.
- The ICS 205 serves as part of the IAP.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Date/Time Prepared	Enter date prepared (month/day/year) and time prepared (using the 24-hour clock).
3	Operational Period • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
4	Basic Radio Channel Use	Enter the following information about radio channel use:
	Zone Group	
	Channel Number	Use at the Communications Unit Leader's discretion. Channel Number (Ch #) may equate to the channel number for incident radios that are programmed or cloned for a specific Communications Plan, or it may be used just as a reference line number on the ICS 205 document.
	Function	Enter the Net function each channel or talkgroup will be used for (Command, Tactical, Ground-to-Air, Air-to-Air, Support, Dispatch)
	Channel Name/Trunked Radio System Talkgroup	Enter the nomenclature or commonly used name for the channel or talkgroup such as the National Interoperability Channels which follow DHS-frequency Field Operations Guide (FOG).
	Assignment	Enter the name of the ICS Branch/Division/Group/Section to which this channel/talkgroup will be assigned.
	RX (Receive) Frequency (N or W)	Enter the Receive Frequency (RX Freq) as the mobile or portable subscriber would be programmed using xxx.xxx out to four decimal places, followed by an "N" designating narrowband or a "W" designating wideband emissions. The name of the specific trunked radio system with which the talkgroup is associated may be entered across all fields on the ICS 205 normally used for conventional channel programming information.
RX Tone/MAC	Enter the Receive Continuous Tone Coded Squelch System (CTCSS) sub-	

		audible tone (RX Tone) or Network Access Code (RX NAC) for the receive frequency as the mobile or portable subscriber would be programmed.
Block Number	Block Title	Instructions
4 (continued)	TX (Transmit) Frequency (N or W)	Enter the Transmit Frequency (TX Freq) as the mobile or portable subscriber would be programmed using xxx,xxx out to four decimal places, followed by an "N" designating narrowband or a "W" designating wideband emissions.
	TX Tone/NAC	Enter the Transmit Continuous Tone Coded Squelch System (CTCSS) sub-audible tone (TX Tone) or Network Access Code (TX NAC) for the transmit frequency as the mobile or portable subscriber would be programmed.
	Mode (A, D, or M)	Enter "A" for analog operation, "D" for digital operation, or "M" for mixed mode operation.
	Remarks	Enter miscellaneous information concerning repeater locations, information concerning patched channels or talkgroups using links or gateways, etc.
5	Special Instructions	Enter any special instructions (e.g., using cross-band repeaters, secure-voice, encoders, private line (PL) tones, etc.) or other emergency communications needs. If needed, also include any special instructions for handling an incident within an incident.
6	Prepared by (Communications Unit Leader) <ul style="list-style-type: none"> ▪ Name ▪ Signature ▪ Date/Time 	Enter the name and signature of the person preparing the form, typically the Communications Unit Leader. Enter date (month/day/year) and time prepared (24-hour clock).

**ICS 205A
Communications List**

Purpose. The Communications List (ICS 205A) records methods of contact for incident personnel. While the Incident Radio Communications Plan (ICS 205) is used to provide information on all radio frequencies down to the Division/Group level, the ICS 205A indicates all methods of contact for personnel assigned to the incident (radio frequencies, phone numbers, pager numbers, etc.), and functions as an incident directory.

Preparation. The ICS 205A can be filled out during check-in and is maintained and distributed by Communications Unit personnel. This form should be updated each operational period.

Distribution. The ICS 205A is distributed within the ICS organization by the Communications Unit, and posted as necessary. All completed original forms must be given to the Documentation Unit. If this form contains sensitive information such as cell phone numbers, it should be clearly marked in the header that it contains sensitive information and is not for public release.

Notes:

- The ICS 205A is an optional part of the Incident Action Plan (IAP).
- This optional form is used in conjunction with the ICS 205.
- If additional pages are needed, use a blank ICS 205A and repaginate as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Basic Local Communications Information	Enter the communications methods assigned and used for personnel by their assigned ICS position.
	• Incident Assigned Position	Enter the ICS organizational assignment.
	• Name	Enter the name of the assigned person.
	• Method(s) of Contact (phone, pager, cell, etc.)	For each assignment, enter the radio frequency and contact number(s) to include area code, etc. If applicable, include the vehicle license or ID number assigned to the vehicle for the incident (e.g., HAZMAT 1, etc.).
4	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

MEDICAL PLAN (ICS 206)

1. Incident Name:		2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____					
3. Medical Aid Stations:							
Name	Location	Contact Number(s)/Frequency	Paramedics on Site?				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
			<input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Transportation (Indicate air or ground):							
Ambulance Service	Location	Contact Number(s)/Frequency	Level of Service				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
			<input type="checkbox"/> ALS <input type="checkbox"/> BLS				
5. Hospitals:							
Hospital Name	Address, Latitude & Longitude if Helipad	Contact Number(s)/Frequency	Travel Time		<input type="checkbox"/> Trauma Center	<input type="checkbox"/> Burn Center	<input type="checkbox"/> Helipad
			Air	Ground			
					<input type="checkbox"/> Yes Level	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
					<input type="checkbox"/> Yes Level	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
					<input type="checkbox"/> Yes Level	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
					<input type="checkbox"/> Yes Level	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
					<input type="checkbox"/> Yes Level	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
6. Special Medical Emergency Procedures:							
<input type="checkbox"/> Check box if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations.							
7. Prepared by (Medical Unit Leader): Name: _____					Signature: _____		

8. Approved by (Safety Officer): Name: _____ Signature: _____		
ICS 206	IAP Page _____	Date/Time: _____

**ICS 206
Medical Plan**

Purpose. The Medical Plan (ICS 206) provides information on incident medical aid stations, transportation services, hospitals, and medical emergency procedures.

Preparation. The ICS 206 is prepared by the Medical Unit Leader and reviewed by the Safety Officer to ensure ICS coordination. If aviation assets are utilized for rescue, coordinate with Air Operations.

Distribution. The ICS 206 is duplicated and attached to the Incident Objectives (ICS 202) and given to all recipients as part of the Incident Action Plan (IAP). Information from the plan pertaining to incident medical aid stations and medical emergency procedures may be noted on the Assignment List (ICS 204). All completed original forms must be given to the Documentation Unit.

Notes:

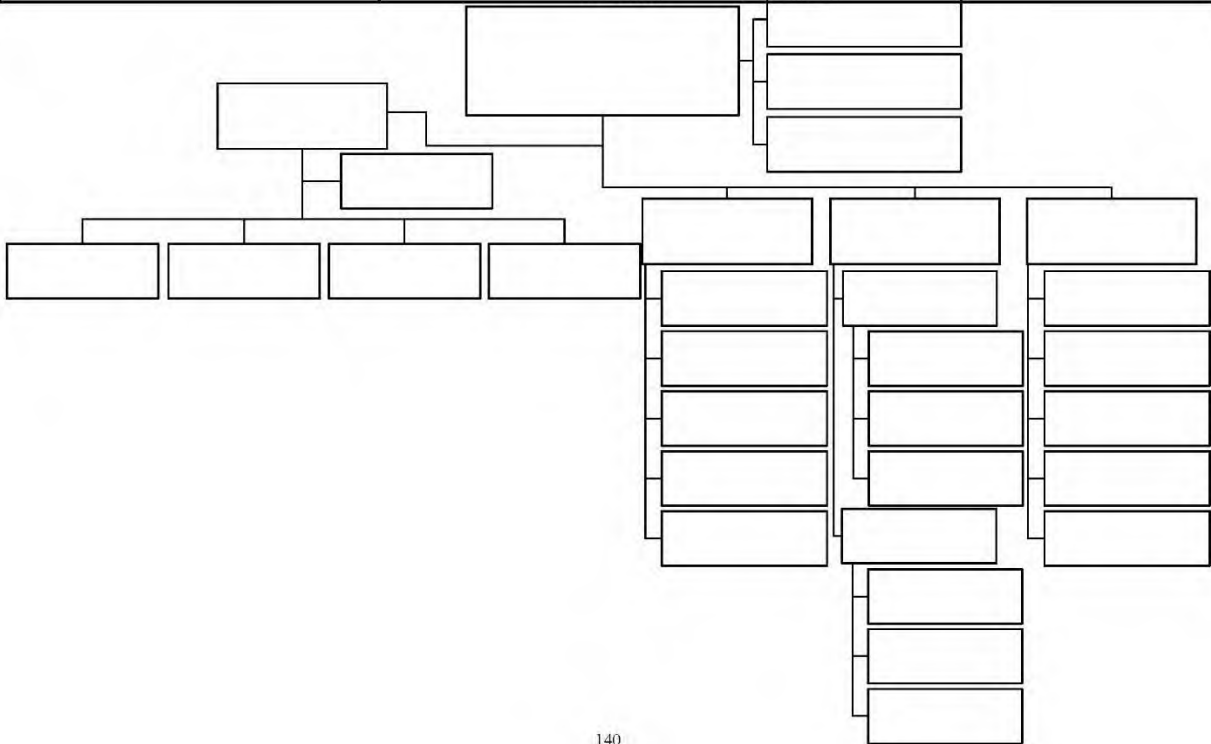
- The ICS 206 serves as part of the IAP.
- This form can include multiple pages.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Medical Aid Stations	Enter the following information on the incident medical aid station(s):
	• Name	Enter name of the medical aid station.
	• Location	Enter the location of the medical aid station (e.g., Staging Area, Camp Ground).
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the medical aid station(s).
	• Paramedics on Site? <input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate (yes or no) if paramedics are at the site indicated.
4	Transportation (Indicate air or ground)	Enter the following information for ambulance services available to the incident:
	• Ambulance Service	Enter name of ambulance service.
	• Location	Enter the location of the ambulance service.
	• Contact Number(s)/Frequency	Enter the contact number(s) and frequency for the ambulance service.
	• Level of Service <input type="checkbox"/> ALS <input type="checkbox"/> BLS	Indicate the level of service available for each ambulance, either ALS (Advanced Life Support) or BLS (Basic Life Support).

Block Number	Block Title	Instructions
5	Hospitals	Enter the following information for hospital(s) that could serve this incident.
	<ul style="list-style-type: none"> Hospital Name 	Enter hospital name and identify any pre-designated medical aircraft by name & frequency.
	<ul style="list-style-type: none"> Address, Latitude & Longitude if Helipad 	Enter the physical address of the hospital and the latitude and longitude if the hospital has a helipad.
	<ul style="list-style-type: none"> Contact Number(s)/ Frequency 	Enter the contact number(s) and/or communications frequency(s) for the hospital.
	<ul style="list-style-type: none"> Travel Time: <ul style="list-style-type: none"> Air Ground 	Enter the travel time by air and ground from the incident to the hospital.
	<ul style="list-style-type: none"> Trauma Center <input type="checkbox"/> Yes /Level _____ 	Indicate yes and the trauma level if the hospital has a trauma center.
	<ul style="list-style-type: none"> Burn Center <input type="checkbox"/> Yes <input type="checkbox"/> No 	Indicate (yes or no) if the hospital has a burn center.
6	<ul style="list-style-type: none"> Helipad <input type="checkbox"/> Yes <input type="checkbox"/> No 	Indicate (yes or no) if the hospital has a helipad. Latitude and Longitude data format need to compliment Medical Evacuation Helicopters and Medical Air Resources.
	<ul style="list-style-type: none"> Special Medical Emergency Procedures 	Note any special emergency instructions for use by incident personnel including (1) who should be contacted, (2) how should they be contacted, and (3) who manages an incident within an incident due to a rescue, accident, etc. Include procedures for how to report medical emergencies.
	<input type="checkbox"/> Check box if aviation assets are utilized for rescue. If assets are used, coordinate with Air Operations.	Self-explanatory. Incident assigned aviation assets should be included in ICS 220.
7	Prepared by (Medical Unit Leader) <ul style="list-style-type: none"> Name Signature 	Enter the name and signature of the person preparing the form, typically the Medical Unit Leader. Enter date (month/day/year) and time prepared (24-hour clock).
8	Approved by (Safety Officer) <ul style="list-style-type: none"> Name Signature Date/Time 	Enter the name of the person who approved the plan, typically the Safety Officer. Enter date (month/day/year) and time reviewed (24-hour clock).

INCIDENT ORGANIZATION CHART (ICS 207)

1. Incident Name:	2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____
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3. Organization Chart

Incident Commander(s)		Liaison Officer	
		Safety Officer	
Operations Section Chief	Public Information Officer		
Staging Area Manager	Planning Section Section Chief	Logistics Chief	Finance/Admin Section Chief
	Resources Unit Ldr.	Support Branch Dir.	Time Unit Ldr.
	Situation Unit Ldr.	Supply Unit Ldr.	Procurement Unit Ldr.
	Documentation Unit Ldr.	Facilities Unit Ldr.	Comp./Claims Unit Ldr.
	Demobilization Unit Ldr.	Ground Spt. Unit Ldr.	Cost Unit Ldr.
		Service Branch Dir.	
		Comms Unit Ldr.	
		Medical Unit Ldr.	
		Food Unit Ldr.	

ICS 207 | IAP Page ___ | 4. Prepared by: Name: _____ Position/Title: _____ Signature: _____ Date/Time: _____

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**ICS 207
Incident Organization Chart**

Purpose. The Incident Organization Chart (ICS 207) provides a **visual wall chart** depicting the ICS organization position assignments for the incident. The ICS 207 is used to indicate what ICS organizational elements are currently activated and the names of personnel staffing each element. An actual organization will be event-specific. The size of the organization is dependent on the specifics and magnitude of the incident and is scalable and flexible. Personnel responsible for managing organizational positions are listed in each box as appropriate.

Preparation. The ICS 207 is prepared by the Resources Unit Leader and reviewed by the Incident Commander. Complete only the blocks where positions have been activated, and add additional blocks as needed, especially for Agency Representatives and all Operations Section organizational elements. For detailed information about positions, consult the NIMS ICS Field Operations Guide. The ICS 207 is intended to be used as a wall-size chart and printed on a plotter for better visibility. A chart is completed for each operational period, and updated when organizational changes occur.

Distribution. The ICS 207 is intended to be **wall mounted** at Incident Command Posts and other incident locations as needed, and is not intended to be part of the Incident Action Plan (IAP). All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 207 is intended to be **wall mounted** (printed on a plotter). Document size can be modified based on individual needs.
- Also available as 8 1/2 x 14 (legal size) chart.
- ICS allows for organizational flexibility, so the Intelligence/Investigative Function can be embedded in several different places within the organizational structure.
- Use additional pages if more than three branches are activated. Additional pages can be added based on individual need (such as to distinguish more Division Groups and Branches as they are activated).

Block Number	Block Title	Instructions
1	Incident Name	Print the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Organization Chart	<ul style="list-style-type: none"> • Complete the incident organization chart. • For all individuals, use at least the first initial and last name. • List agency where it is appropriate, such as for Unified Commanders. • If there is a shift change during the specified operational period, list both names, separated by a slash.
4	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

5. Prepared by: Name: _____		Position/Title: _____	Signature: _____
ICS 208	IAP Page _____	Date/Time: _____	

**ICS 208
Safety Message/Plan**

Purpose. The Safety Message/Plan (ICS 208) expands on the Safety Message and Site Safety Plan.

Preparation. The ICS 208 is an optional form that may be included and completed by the Safety Officer for the Incident Action Plan (IAP).

Distribution. The ICS 208, if developed, will be reproduced with the IAP and given to all recipients as part of the IAP. All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 208 may serve (optionally) as part of the IAP.
- Use additional copies for continuation sheets as needed, and indicate pagination as used.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Safety Message/Expanded Safety Message, Safety Plan, Site Safety Plan	Enter clear, concise statements for safety message(s), priorities, and key command emphasis/decisions/directions. Enter information such as known safety hazards and specific precautions to be observed during this operational period. If needed, additional safety message(s) should be referenced and attached.
4	Site Safety Plan Required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Check whether or not a site safety plan is required for this incident.
	Approved Site Safety Plan(s) Located At	Enter where the approved Site Safety Plan(s) is located.
5	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

SITE SAFETY AND CONTROL PLAN ICS 208 HM		1. Incident Name:	2. Date Prepared:	3. Operational Period: Time:								
Section I. Site Information												
4. Incident Location:												
Section II. Organization												
5. Incident Commander:			6. HM Group Supervisor:				7. Tech. Specialist - HM Reference:					
8. Safety Officer:			9. Entry Leader:				10. Site Access Control Leader:					
11. Asst. Safety Officer - HM:			12. Decontamination Leader:				13. Safe Refuge Area Mgr:					
14. Environmental Health:			15.				16.					
17. Entry Team: (Buddy System) Name: PPE Level						18. Decontamination Element Name: PPE Level						
Entry 1						Decon 1						
Entry 2						Decon 2						
Entry 3						Decon 3						
Entry 4						Decon 4						
Section III. Hazard/Risk Analysis												
19. Material:	Container type	Qty.	Phys State	pH	IDLH	F.P.	I.T.	V.P.	V.D.	S.G.	LEL	UEL
Comment:												
Section IV. Hazard Monitoring												
20. LEL Instrument(s):						21. O ₂ Instrument(s):						
22. Toxicity/PPM Instrument(s):						23. Radiological Instrument(s):						
Comment:												
Section V. Decontamination Procedures												
24. Standard Decontamination Procedures:									YES:	NO:		
Comment:												
Section VI. Site Communications												
25. Command Frequency:				26. Tactical Frequency:				27. Entry Frequency:				
Section VII. Medical Assistance												
28. Medical Monitoring:		YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>	29. Medical Treatment and Transport In-place:			YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>

Comment



Section VIII. Site Map

30. Site Map:

Weather Command Post Zones Assembly Areas Escape Routes Other

Section IX. Entry Objectives

Entry Objectives:

Section X. SOP S and Safe Work Practices

31. Modifications to Documented SOP s or Work Practices:
Comment:

YES: NO:

Section XI. Emergency Procedures

32. Emergency Procedures:

Section XII. Safety Briefing

33. Asst. Safety Officer - HM Signature:

Safety Briefing Completed (Time):

34. HM Group Supervisor Signature:

36. Incident Commander Signature:

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**INSTRUCTIONS FOR COMPLETING THE SITE SAFETY AND CONTROL
PLAN ICS 208 HM**

A Site Safety and Control Plan must be completed by the Hazardous Materials Group Supervisor and reviewed by all within the Hazardous Materials Group prior to operations commencing within the Exclusion Zone.

Item Number	Item Title	Instructions
1.	Incident Name/Number	Print name and/or incident number.
2.	Date and Time	Enter date and time prepared.
3.	Operational Period	Enter the time interval for which the form applies.
4.	Incident Location	Enter the address and or map coordinates of the incident.
5 - 16.	Organization	Enter names of all individuals assigned to ICS positions. (Entries 5 & 8 mandatory). Use Boxes 15 and 16 for other functions: i.e. Medical Monitoring.
17 - 18.	Entry Team/Decon Element	Enter names and level of PPE of Entry & Decon personnel. (Entries 1 - 4 mandatory buddy system and back-up.)
19.	Material	Enter names and pertinent information of all known chemical products. Enter UNK if material is not known. Include any which apply to chemical properties. (Definitions: ph = Potential for Hydrogen (Corrosivity), IDLH = Immediately Dangerous to Life and Health, F.P. = Flash Point, I.T. = Ignition Temperature, V.P. = Vapor Pressure, V.D. = Vapor Density, S.G. = Specific Gravity, LEL = Lower Explosive Limit, UEL = Upper Explosive Limit)
20 - 23.	Hazard Monitoring	List the instruments which will be used to monitor for chemical.
24.	Decontamination Procedures	Check NO if modifications are made to standard decontamination procedures and make appropriate Comments including type of solutions.
25 - 27.	Site Communications	Enter the radio frequency(ies) which apply.
28 - 29.	Medical Assistance	Enter comments if NO is checked.
30.	Site Map	Sketch or attach a site map which defines all locations and layouts of operational zones. (Check boxes are mandatory to be identified.)
31.	Entry Objectives	List all objectives to be performed by the Entry Team in the Exclusion Zone and any parameters which will alter or stop entry operations.
32 - 33.	SOP s, Safe Work Practices, and Emergency Procedures	List in Comments if any modifications to SOP s and any emergency procedures which will be affected if an emergency occurs while personnel are within the Exclusion Zone.
34 - 36.	Safety Briefing	Have the appropriate individual place their signature in the box once the Site Safety and Control Plan is reviewed. Note the time in box 34 when the safety briefing has been completed.

INCIDENT STATUS SUMMARY (ICS 209)

*1. Incident Name:		*2. Incident Number:		
*3. Report Version (check one box or left): <input type="checkbox"/> Initial Rpt # <input type="checkbox"/> Update (if used) <input type="checkbox"/> Final		*4. Incident Commander(s) & Agency or Organization:	*5. Incident Management Organization:	*6. Incident Start Date/Time: Date: _____ Time: _____ Time Zone: _____
*7. Current Incident Size or Area Involved (use unit label - e.g., "sq mi," "city block"):	# Percent (%) Contained Completed: _____	*8. Incident Definition:	*10. Incident Complexity Level:	*11. For Time Period: From Date/Time: _____ To Date/Time: _____

Approval & Routing Information

*12. Prepared By: Print Name: _____ ICS Position: _____ Date/Time Prepared: _____		*13. Date/Time Submitted: Time Zone: _____	
*14. Approved By: Print Name: _____ ICS Position: _____ Signature: _____		*15. Primary Location, Organization, or Agency Sent To:	

Incident Location Information

*16. State:	*17. County/Parish/Borough:	*18. City:
*19. Unit or Other:	*20. Incident Jurisdiction:	*21. Incident Location Ownership (if different than jurisdiction):
*22. Longitude (indicate format): Latitude (indicate format):	*23. US National Grid Reference:	*24. Legal Description (township, section, range):
*25. Short Location or Area Description (list all affected areas or a reference point):		*26. UTM Coordinates:
*27. Note any electronic geospatial data included or attached (indicate data format, content, and collection time information and labels):		

Incident Summary

*28. Significant Events for the Time Period Reported (summarize significant progress made, evaluations, incident growth, etc.):					
*29. Primary Materials or Hazards Involved (hazardous chemicals, fuel types, infectious agents, radiation, etc.):					
*30. Damage Assessment Information (summarize damage and/or restriction of use or availability to residential or commercial property, natural resources, critical infrastructure and key resources, etc.):		A. Structural Summary	B. # Threatened (72 hrs)	C. # Damaged	D. # Destroyed
		E. Single Residences			
		F. Nonresidential Commercial Property			
		Other Minor Structures			

		Other			
ICS 209, Page 1 of ____		* Required when applicable.			

37. Strategic Objectives (define planned end-state for incident):	
ICS 209, Page 2 of ____	* Required when applicable.

INCIDENT STATUS SUMMARY (ICS 209)

*1. Incident Name:	2. Incident Number:
<i>Additional Incident Decision Support Information (continued)</i>	
<p>38. Current Incident Threat Summary and Risk Information in 12-, 24-, 48-, and 72-hour timeframes and beyond. Summarize primary incident threats to life, property, communities and community stability, residences, health care facilities, other critical infrastructure and key resources, commercial facilities, natural and environmental resources, cultural resources, and continuity of operations and/or business. Identify corresponding incident-related potential economic or cascading impacts.</p> <p>12 hours:</p> <p>24 hours:</p> <p>48 hours:</p> <p>72 hours:</p> <p>Anticipated after 72 hours:</p>	
<p>39. Critical Resource Needs in 12-, 24-, 48-, and 72-hour timeframes and beyond to meet critical incident objectives. List resource category, kind, and/or type, and amount needed, in priority order.</p> <p>12 hours:</p> <p>24 hours:</p> <p>48 hours:</p> <p>72 hours:</p> <p>Anticipated after 72 hours:</p>	
<p>40. Strategic Discussion: Explain the relation of overall strategy, constraints, and current available information to:</p> <ul style="list-style-type: none"> 1) critical resource needs identified above, 2) the Incident Action Plan and management objectives and targets, 3) anticipated results. <p>Explain major problems and concerns such as operational challenges, incident management problems, and social, political, economic, or environmental concerns or impacts.</p>	
<p>41. Planned Actions for Next Operational Period:</p>	
<p>42. Projected Final Incident Size/Area (use unit label – e.g., "sq mi"):</p>	
<p>43. Anticipated Incident Management Completion Date:</p>	
<p>44. Projected Significant Resource Demobilization Start Date:</p>	
<p>45. Estimated Incident Costs to Date:</p>	
<p>46. Projected Final Incident Cost Estimate:</p>	

47. Remarks (or continuation of any blocks above – list block number in notation):	
ICS 209, Page 3 of ____	* Required when applicable.

53. Additional Cooperating and Assisting Organizations Not Listed Above:	
ICS 209, Page ___ of ___	* Required when applicable.

ICS 209

Incident Status Summary

Purpose. The ICS 209 is used for reporting information on significant incidents. It is not intended for every incident, as most incidents are of short duration and do not require scarce resources, significant mutual aid, or additional support and attention. The ICS 209 contains basic information elements needed to support decisionmaking at all levels above the incident to support the incident. Decisionmakers may include the agency having jurisdiction, but also all multiagency coordination system (MACS) elements and parties, such as cooperating and assisting agencies/organizations, dispatch centers, emergency operations centers, administrators, elected officials, and local, tribal, county, State, and Federal agencies. Once ICS 209 information has been submitted from the incident, decisionmakers and others at all incident support and coordination points may transmit and share the information (based on its sensitivity and appropriateness) for access and use at local, regional, State, and national levels as it is needed to facilitate support.

Accurate and timely completion of the ICS 209 is necessary to identify appropriate resource needs, determine allocation of limited resources when multiple incidents occur, and secure additional capability when there are limited resources due to constraints of time, distance, or other factors. The information included on the ICS 209 influences the priority of the incident, and thus its share of available resources and incident support.

The ICS 209 is designed to provide a "snapshot in time" to effectively move incident decision support information where it is needed. It should contain the most accurate and up-to-date information available at the time it is prepared. However, readers of the ICS 209 may have access to more up-to-date or real-time information in reference to certain information elements on the ICS 209. Coordination among communications and information management elements within ICS and among MACS should delineate authoritative sources for more up-to-date and/or real-time information when ICS 209 information becomes outdated in a quickly evolving incident.

Reporting Requirements. The ICS 209 is intended to be used when an incident reaches a certain threshold where it becomes significant enough to merit special attention, require additional resource support needs, or cause media attention, increased public safety threat, etc. Agencies or organizations may set reporting requirements and, therefore, ICS 209s should be completed according to each jurisdiction or discipline's policies, mobilization guide, or preparedness plans. It is recommended that consistent ICS 209 reporting parameters be adopted and used by jurisdictions or disciplines for consistency over time, documentation, efficiency, trend monitoring, incident tracking, etc.

For example, an agency or MAC (Multiagency Coordination) Group may require the submission of an initial ICS 209 when a new incident has reached a certain predesignated level of significance, such as when a given number of resources are committed to the incident, when a new incident is not completed within a certain timeframe, or when impacts/threats to life and safety reach a given level.

Typically, ICS 209 forms are completed either once daily or for each operational period – in addition to the initial submission. Jurisdictional or organizational guidance may indicate frequency of ICS 209 submission for particular definitions of incidents or for all incidents. This specific guidance may help determine submission timelines when operational periods are extremely short (e.g., 2 hours) and it is not necessary to submit new ICS 209 forms for all operational periods.

Any plans or guidelines should also indicate parameters for when it is appropriate to stop submitting ICS 209s for an incident, based upon incident activity and support levels.

Preparation. When an Incident Management Organization (such as an Incident Management Team) is in place, the Situation Unit Leader or Planning Section Chief prepares the ICS 209 at the incident. On other incidents, the ICS 209 may be completed by a dispatcher in the local communications center, or by another staff person or manager. This form should be completed at the incident or at the closest level to the incident.

The ICS 209 should be completed with the best possible, currently available, and verifiable information at the time it is completed and signed.

This form is designed to serve incidents impacting specific geographic areas that can easily be defined. It also has the flexibility for use on ubiquitous events, or those events that cover extremely large areas and that may involve many jurisdictions and ICS organizations. For these incidents, it will be useful to clarify on the form exactly which portion of the larger incident the ICS 209 is meant to address. For example, a particular ICS 209 submitted during a statewide outbreak

of mumps may be relevant only to mumps-related activities in Story County, Iowa. This can be indicated in both the incident name, Block 1, and in the Incident Location Information section in Blocks 16–26.

While most of the "Incident Location Information" in Blocks 16–26 is optional, the more information that can be submitted, the better. Submission of multiple location indicators increases accuracy, improves interoperability, and increases information sharing between disparate systems. Preparers should be certain to follow accepted protocols or standards when entering location information, and clearly label all location information. As with other ICS 209 data, geospatial information may be widely shared and utilized, so accuracy is essential.

If electronic data is submitted with the ICS 209, do not attach or send extremely large data files. Incident geospatial data that is distributed with the ICS 209 should be in simple incident geospatial basics, such as the incident perimeter, point of origin, etc. Data file sizes should be small enough to be easily transmitted through dial-up connections or other limited communications capabilities when ICS 209 information is transmitted electronically. Any attached data should be clearly labeled as to format content and collection time, and should follow existing naming conventions and standards.

Distribution. ICS 209 information is meant to be completed at the level as close to the incident as possible, preferably at the incident. Once the ICS 209 has been submitted outside the incident to a dispatch center or MACS element, it may subsequently be transmitted to various incident supports and coordination entities based on the support needs and the decisions made within the MACS in which the incident occurs.

Coordination with public information system elements and investigative/intelligence information organizations at the incident and within MACS is essential to protect information security and to ensure optimal information sharing and coordination. There may be times in which particular ICS 209s contain sensitive information that should not be released to the public (such as information regarding active investigations, fatalities, etc.). When this occurs, the ICS 209 (or relevant sections of it) should be labeled appropriately, and care should be taken in distributing the information within MACS.

All completed and signed original ICS 209 forms **MUST** be given to the incident's Documentation Unit and/or maintained as part of the official incident record.

Notes:

- To promote flexibility, only a limited number of ICS 209 blocks are typically required, and most of these are required only when applicable.
- Most fields are optional, to allow responders to use the form as best fits their needs and protocols for information collection.
- For the purposes of the ICS 209, responders are those personnel who are assigned to an incident or who are a part of the response community as defined by NIMS. This may include critical infrastructure owners and operators, nongovernmental and nonprofit organizational personnel, and contract employees (such as caterers), depending on local/jurisdictional/discipline practices.
- For additional flexibility only pages 1–3 are numbered, for two reasons:
 - Possible submission of additional pages for the Remarks Section (Block 47) and
 - Possible submission of additional copies of the fourth/last page (the "Incident Resource Commitment Summary") to provide a more detailed resource summary.

Block Number	Block Title	Instructions
*1	Incident Name	<p>REQUIRED BLOCK.</p> <ul style="list-style-type: none"> • Enter the full name assigned to the incident. • Check spelling of the full incident name. • For an incident that is a Complex, use the word "Complex" at the end of the incident name. • If the name changes, explain comments in Remarks, Block 47. • Do not use the same incident name for different incidents in the same calendar year.

Block Number	Block Title	Instructions
2	Incident Number	<ul style="list-style-type: none"> Enter the appropriate number based on current guidance. The incident number may vary by jurisdiction and discipline. Examples include: <ul style="list-style-type: none"> A computer-aided dispatch (CAD) number. An accounting number. A county number. A disaster declaration number. A combination of the State, unit/agency ID, and a dispatch system number. A mission number. Any other unique number assigned to the incident and derived by means other than those above. Make sure the number entered is correct. Do not use the same incident number for two different incidents in the same calendar year. Incident numbers associated with host jurisdictions or agencies and incident numbers assigned by agencies represented in Unified Command should be listed, or indicated in Remarks, Block 47.
*3	Report Version (check one box on left)	REQUIRED BLOCK. <ul style="list-style-type: none"> This indicates the current version of the ICS 209 form being submitted. If only one ICS 209 will be submitted, check BOTH "Initial" and "Final" (or check only "Final").
	<input type="checkbox"/> Initial	Check "Initial" if this is the first ICS 209 for this incident.
	<input type="checkbox"/> Update	Check "Update" if this is a subsequent report for the same incident. These can be submitted at various time intervals (see "Reporting Requirements" above).
	<input type="checkbox"/> Final	<ul style="list-style-type: none"> Check "Final" if this is the last ICS 209 to be submitted for this incident (usually when the incident requires only minor support that can be supplied by the organization having jurisdiction). Incidents may also be marked as "Final" if they become part of a new Complex (when this occurs, it can be indicated in Remarks, Block 47).
	Report # (if used)	Use this optional field if your agency or organization requires the tracking of ICS 209 report numbers. Agencies may also track the ICS 209 by the date/time submitted.
*4	Incident Commander(s) & Agency or Organization	REQUIRED BLOCK. <ul style="list-style-type: none"> Enter both the first and last name of the Incident Commander. If the incident is under a Unified Command, list all Incident Commanders by first initial and last name separated by a comma, including their organization. For example: L. Burnett – Minneapolis FD, R. Domanski – Minneapolis PD, C. Taylor – St. Paul PD, Y. Martin – St. Paul FD, S. McIntyre – U.S. Army Corps, J. Hartl – NTSB
5	Incident Management Organization	Indicate the incident management organization for the incident, which may be a Type 1, 2, or 3 Incident Management Team (IMT), a Unified Command, a Unified Command with an IMT, etc. This block should not be completed unless a recognized incident management organization is assigned to the incident.

Block Number	Block Title	Instructions
6	Incident Start Date/Time	REQUIRED. This is always the start date and time of the incident (not the report date and time or operational period).
	Date	Enter the start date (month/day/year)
	Time	Enter the start time (using the 24-hour clock)
	Time Zone	Enter the time zone of the incident (e.g., EDT, PST).
7	Current Incident Size or Area Involved (use unit label – e.g., "sq mi" "city block")	<ul style="list-style-type: none"> Enter the appropriate incident descriptive size or area involved (acres, number of buildings, square miles, hectares, square kilometers, etc.) Enter the total area involved for incident complexes in this block, and list each sub-incident and size in Remarks (Block 47). Indicate that the size is an estimate, if a more specific figure is not available. Incident size may be a population figure rather than a geographic figure, depending on the incident definition and objectives. If the incident involves more than one jurisdiction or mixed ownership, agencies/organizations may require listing a size breakdown by organization, or including this information in Remarks (Block 47). The incident may be one part of a much larger event (refer to introductory instructions under "Preparation"). Incident size/area depends on the area actively managed within the incident objectives and incident operations, and may also be defined by a delegation of authority or letter of expectation outlining management bounds.
8	Percent (%) Contained or Completed (circle one)	<ul style="list-style-type: none"> Enter the percent that this incident is completed or contained (e.g., 50%), with a % label. For example, a spill may be 85% contained, or flood response objectives may be 50% met.
9	Incident Definition	REQUIRED BLOCK. Enter a general definition of the incident in this block. This may be a general incident category or kind description, such as "tornado," "wildfire," "bridge collapse," "civil unrest," "parade," "vehicle fire," "mass casualty," etc.
10	Incident Complexity Level	Identify the incident complexity level as determined by Unified/Incident Commanders, if available or used.
11	For Time Period	REQUIRED BLOCK. <ul style="list-style-type: none"> Enter the time interval for which the form applies. This period should include all of the time since the last ICS 209 was submitted, or if it is the initial ICS 209, it should cover the time lapsed since the incident started. The time period may include one or more operational periods, based on agency/organizational reporting requirements.
	From Date/Time	<ul style="list-style-type: none"> Enter the start date (month/day/year). Enter the start time (using the 24-hour clock).
	To Date/Time	<ul style="list-style-type: none"> Enter the end date (month/day/year). Enter the end time (using the 24-hour clock).

Block Number	Block Title	Instructions
APPROVAL & ROUTING INFORMATION		
*12	Prepared By	REQUIRED BLOCK. When an incident management organization is in place, this would be the Situation Unit Leader or Planning Section Chief at the incident. On other incidents, it could be a dispatcher in the local emergency communications center, or another staff person or manager.
	Print Name	Print the name of the person preparing the form.
	ICS Position	The ICS title of the person preparing the form (e.g., "Situation Unit Leader").
	Date/Time Prepared	Enter the date (month/day/year) and time (using the 24-hour clock) the form was prepared. Enter the time zone if appropriate.
*13	Date/Time Submitted	REQUIRED. Enter the submission date (month/day/year) and time (using the 24-hour clock).
	Time Zone	Enter the time zone from which the ICS 209 was submitted (e.g., EDT, PST).
*14	Approved By	REQUIRED. When an incident management organization is in place, this would be the Planning Section Chief or Incident Commander at the incident. On other incidents, it could be the jurisdiction's dispatch center manager, organizational administrator, or other manager.
	Print Name	Print the name of the person approving the form.
	ICS Position	The position of the person signing the ICS 209 should be entered (e.g., "Incident Commander").
	Signature	Signature of the person approving the ICS 209, typically the Incident Commander. The original signed ICS 209 should be maintained with other incident documents.
*15	Primary Location, Organization, or Agency Sent To	REQUIRED BLOCK. Enter the appropriate primary location or office the ICS 209 was sent to, apart from the incident. This most likely is the entity or office that ordered the incident management organization that is managing the incident. This may be a dispatch center or a MACS element such as an emergency operations center. If a dispatch center or other emergency center prepared the ICS 209 for the incident, indicate where it was submitted initially.
INCIDENT LOCATION INFORMATION		
<ul style="list-style-type: none"> • Much of the "Incident Location Information" in Blocks 15-26 is optional, but completing as many fields as possible increases accuracy, and improves interoperability and information sharing between disparate systems. • As with all ICS 209 information, accuracy is essential because the information may be widely distributed and used in a variety of systems. Location and/or geospatial data may be used for maps, reports, and analysis by multiple parties outside the incident. • Be certain to follow accepted protocols, conventions, or standards where appropriate when submitting location information, and clearly label all location information. • Incident location information is usually based on the point of origin of the incident, and the majority of the area where the incident jurisdiction is. 		

*16	State	<p>REQUIRED BLOCK WHEN APPLICABLE.</p> <ul style="list-style-type: none"> • Enter the State where the incident originated. • If other States or jurisdictions are involved, enter them in Block 25 or Block 44.
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Block Number	Block Title	Instructions
*17	County / Parish / Borough	<p>REQUIRED BLOCK WHEN APPLICABLE.</p> <ul style="list-style-type: none"> • Enter the county, parish, or borough where the incident originated. • If other counties or jurisdictions are involved, enter them in Block 25 or Block 47.
*18	City	<p>REQUIRED BLOCK WHEN APPLICABLE.</p> <ul style="list-style-type: none"> • Enter the city where the incident originated. • If other cities or jurisdictions are involved, enter them in Block 25 or Block 47.
19	Unit or Other	Enter the unit, sub-unit, unit identification (ID) number or code (if used), or other information about where the incident originated. This may be a local identifier that indicates primary incident jurisdiction or responsibility (e.g., police, fire, public works, etc.) or another type of organization. Enter specifics in Block 25.
*20	Incident Jurisdiction	<p>REQUIRED BLOCK WHEN APPLICABLE.</p> <p>Enter the jurisdiction where the incident originated (the entry may be general, such as Federal, city, or State, or may specifically identify agency names such as Warren County, U.S. Coast Guard, Panama City, NYFD).</p>
21	Incident Location Ownership (if different than jurisdiction)	<ul style="list-style-type: none"> • When relevant, indicate the ownership of the area where the incident originated, especially if it is different than the agency having jurisdiction. • This may include situations where jurisdictions contract for emergency services, or where it is relevant to include ownership by private entities such as a large industrial site.
22	<p>22. Longitude (Indicate format):</p> <p>Latitude (Indicate format):</p>	<ul style="list-style-type: none"> • Enter the longitude and latitude where the incident originated, if available and normally used by the authority having jurisdiction for the incident. • Clearly label the data, as longitude and latitude can be derived from various sources. For example, if degrees, minutes, and seconds are used, label as "33 degrees, 45 minutes, 01 seconds."
23	US National Grid Reference	<ul style="list-style-type: none"> • Enter the US National Grid (USNG) reference where the incident originated, if available and commonly used by the agencies/jurisdictions with primary responsibility for the incident. • Clearly label the data.
24	Legal Description (township, section, range)	<ul style="list-style-type: none"> • Enter the legal description where the incident originated, if available and commonly used by the agencies/jurisdictions with primary responsibility for the incident. • Clearly label the data (e.g., N 1/2 SE 1/4, SW 1/4, S24, T32N, R18E).

25	Short Location or Area Description (list all affected areas or a reference point)	REQUIRED BLOCK. <ul style="list-style-type: none"> List all affected areas as described in instructions for Blocks 16–24 above, OR summarize a general location, OR list a reference point for the incident (e.g., "the southern third of Florida," "in ocean 20 miles west of Catalina Island, CA," or "within a 5 mile radius of Walden, CO"). This information is important for readers unfamiliar with the area (or with other location identification systems) to be able to quickly identify the general location of the incident on a map. Other location information may also be listed here if needed or relevant for incident support (e.g., base meridian).
26	UTM Coordinates	Indicate Universal Transverse Mercator reference coordinates if used by the discipline or jurisdiction.

Block Number	Block Title	Instructions
27	Note any electronic geospatial data included or attached (indicate data format, content, and collection time information and labels)	<ul style="list-style-type: none"> Indicate whether and how geospatial data is included or attached. Utilize common and open geospatial data standards. WARNING: Do not attach or send extremely large data files with the ICS 209. Incident geospatial data that is distributed with the ICS 209 should be simple incident geospatial basins, such as the incident perimeter, origin, etc. Data file sizes should be small enough to be easily transmitted through dial-up connections or other limited communications capabilities when ICS 209 information is transmitted electronically. NOTE: Clearly indicate data content. For example, data may be about an incident perimeter (such as a shape file), the incident origin (a point), a point and radius (such as an evacuation zone), or a line or lines (such as a pipeline). NOTE: Indicate the data format (e.g., .shp, .kml, .kmz, or .gml file) and any relevant information about projection, etc. NOTE: Include a hyperlink or other access information if incident map data is posted online or on an FTP (file transfer protocol) site to facilitate downloading and minimize information requests. NOTE: Include a point of contact for getting geospatial incident information, if included in the ICS 209 or available and supporting the incident.
INCIDENT SUMMARY		

*28	Significant Events for the Time Period Reported (summarize significant progress made, evacuations, incident growth, etc.)	REQUIRED BLOCK. <ul style="list-style-type: none"> • Describe significant events that occurred during the period being reported in Block 6. Examples include: <ul style="list-style-type: none"> ◦ Road closures. ◦ Evacuations. ◦ Progress made and accomplishments. ◦ Incident command transitions. ◦ Repopulation of formerly evacuated areas and specifics. ◦ Containment. • Refer to other blocks in the ICS 209 when relevant for additional information (e.g., "Details on evacuations may be found in Block 33"), or in Remarks, Block 47. • Be specific and detailed in reference to events. For example, references to road closures should include road number and duration of closure (or include further detail in Block 33). Use specific metrics if needed, such as the number of people or animals evacuated, or the amount of a material spilled and/or recovered. • This block may be used for a single-paragraph synopsis of overall incident status.
29	Primary Materials or Hazards Involved (hazardous chemicals, fuel types, infectious agents, radiation, etc.)	<ul style="list-style-type: none"> • When relevant, enter the appropriate primary materials, fuels, or other hazards involved in the incident that are leaking, burning, infecting, or otherwise influencing the incident. • Examples include hazardous chemicals, wildland fuel models, biohazards, explosive materials, oil, gas, structural collapse, avalanche activity, criminal activity, etc.
	Other	Enter any miscellaneous issues which impacted Critical Infrastructure and Key Resources.

Block Number	Block Title	Instructions
30	Damage Assessment Information (summarize damage and/or restriction of use or availability to residential or commercial property, natural resources, critical infrastructure and key resources, etc.)	<ul style="list-style-type: none"> • Include a short summary of damage or use/access restrictions/limitations caused by the incident for the reporting period, and cumulatively. • Include if needed any information on the facility status, such as operational status, if it is evacuated, etc. when needed. • Include any critical infrastructure or key resources damaged/destroyed/impacted by the incident, the kind of infrastructure, and the extent of damage and/or impact and any known cascading impacts. • Refer to more specific or detailed damage assessment forms and packages when they are used and/or relevant.
	A. Structural Summary	Complete this table as needed based on the definitions for 30B–F below. Note in table or in text block if numbers entered are estimates or are confirmed. Summaries may also include impact to Shoreline and Wildlife, etc.
	B. # Threatened (72 hrs)	Enter the number of structures potentially threatened by the incident within the next 72 hours, based on currently available information.
	C. # Damaged	Enter the number of structures damaged by the incident.
	D. # Destroyed	Enter the number of structures destroyed beyond repair by the incident.
	E. Single Residences	Enter the number of single dwellings/homes/units impacted in Columns 30B–D. Note any specifics in the text block if needed, such as type of residence (apartments, condominiums, single-family homes, etc.).
	F. Nonresidential Commercial Properties	Enter the number of buildings or units impacted in Columns 30B–D. This includes any primary structure used for nonresidential purposes, excluding Other Minor Structures (Block 30G). Note any specifics regarding building or unit types in the text block.
	Other Minor Structures	Enter any miscellaneous structures impacted in Columns 30B–D not covered in 30B–F above, including any minor structures such as booths, sheds, or outbuildings.
Other	Enter any miscellaneous issues which impacted Critical Infrastructure and Key Resources.	

Block Number	Block Title	Instructions
ADDITIONAL INCIDENT DECISION SUPPORT INFORMATION (PAGE 2)		
*31	Public Status Summary	<ul style="list-style-type: none"> This section is for summary information regarding incident-related injuries, illness, and fatalities for civilians (or members of the public); see 31C–N below. Explain or describe the nature of any reported injuries, illness, or other activities in Life, Safety, and Health Status/Threat Remarks (Block 33). Illnesses include those that may be caused through a biological event such as an epidemic or an exposure to toxic or radiological substances. NOTE: Do not estimate any fatality information. NOTE: Please use caution when reporting information in this section that may be on the periphery of the incident or change frequently. This information should be reported as accurately as possible as a snapshot in time, as much of the information is subject to frequent change. NOTE: Do not complete this block if the incident covered by the ICS 209 is <i>not directly responsible</i> for these actions (such as evacuations, sheltering, immunizations, etc.) <i>even if they are related to the incident.</i> <ul style="list-style-type: none"> Only the authority having jurisdiction should submit reports for these actions, to mitigate multiple/conflicting reports. For example, if managing evacuation shelters is part of the incident operation itself, do include these numbers in Block 31J with any notes in Block 33. NOTE: When providing an estimated value, denote in parenthesis: "(est)." <p>Handling Sensitive Information</p> <ul style="list-style-type: none"> Release of information in this section should be carefully coordinated within the incident management organization to ensure synchronization with public information and investigative/intelligence actions. Thoroughly review the "Distribution" section in the introductory ICS 209 instructions for details on handling sensitive information. Use caution when providing information in any situation involving fatalities, and verify that appropriate notifications have been made prior to release of this information. Electronic transmission of any ICS 209 may make information available to many people and networks at once. Information regarding fatalities should be cleared with the Incident Commander and/or an organizational administrator prior to submission of the ICS 209.
	A. # This Reporting Period	Enter the total number of individuals impacted in each category for this reporting period (since the previous ICS 209 was submitted).
	B. Total # to Date	<ul style="list-style-type: none"> Enter the total number of individuals impacted in each category for the entire duration of the incident. This is a cumulative total number that should be adjusted each reporting period.
	C. Indicate Number of Civilians (Public) Below	<ul style="list-style-type: none"> For lines 31D–M below, enter the number of civilians affected for each category. Indicate if numbers are estimates; for those blocks where this is an option. Civilians are those members of the public who are affected by the incident, but who are not included as part of the response effort through Unified Command partnerships and those organizations and agencies assisting and cooperating with response efforts.

D. Fatalities	<ul style="list-style-type: none"> Enter the number of <i>confirmed</i> civilian/public fatalities. See information in introductory instructions ("Distribution") and in Block 31 instructions regarding sensitive handling of fatality information.
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Block Number	Block Title	Instructions
	E. With Injuries/Illness	Enter the number of civilian/public injuries or illnesses directly related to the incident. Injury or illness is defined by the incident or jurisdiction(s).
*31 (continued)	F. Trapped/In Need of Rescue	Enter the number of civilians who are trapped or in need of rescue due to the incident.
	G. Missing (note if estimated)	Enter the number of civilians who are missing due to the incident. Indicate if an estimate is used.
	H. Evacuated (note if estimated)	Enter the number of civilians who are evacuated due to the incident. These are likely to be best estimates, but indicate if they are estimated.
	I. Sheltering-in-Place (note if estimated)	Enter the number of civilians who are sheltering in place due to the incident. Indicate if estimates are used.
	J. In Temporary Shelters (note if estimated)	Enter the number of civilians who are in temporary shelters as a direct result of the incident, noting if the number is an estimate.
	K. Have Received Mass Immunizations	Enter the number of civilians who have received mass immunizations due to the incident and/or as part of incident operations. Do not estimate.
	L. Require Mass Immunizations (note if estimated)	Enter the number of civilians who require mass immunizations due to the incident and/or as part of incident operations. Indicate if it is an estimate.
	M. In Quarantine	Enter the number of civilians who are in quarantine due to the incident and/or as part of incident operations. Do not estimate.
N. Total # Civilians (Public) Affected	Enter sum totals for Columns 31A and 31B for Rows 31D–M.	

32	Responder Status Summary	<ul style="list-style-type: none"> This section is for summary information regarding incident-related injuries, illness, and fatalities for responders; see 32C–N. Illnesses include those that may be related to a biological event such as an epidemic or an exposure to toxic or radiological substances directly in relation to the incident. Explain or describe the nature of any reported injuries, illness, or other activities in Block 33. NOTE: Do not estimate any fatality information or responder status information. NOTE: Please use caution when reporting information in this section that may be on the periphery of the incident or change frequently. This information should be reported as accurately as possible as a snapshot in time, as much of the information is subject to frequent change. NOTE: Do not complete this block if the incident covered by the ICS 209 is not directly responsible for these actions (such as evacuations, sheltering, immunizations, etc.) even if they are related to the incident. Only the authority having jurisdiction should submit reports for these actions, to mitigate multiple/conflicting reports. <p>Handling Sensitive Information</p> <ul style="list-style-type: none"> Release of information in this section should be carefully coordinated within the incident management organization to ensure synchronization with public information and investigative/intelligence actions. Thoroughly review the "Distribution" section in the introductory ICS 209 instructions for details on handling sensitive information. Use caution when providing information in any situation involving fatalities, and verify that appropriate notifications have been made prior to release of this information. Electronic transmission of any ICS 209 may make information available to many people and networks at once. Information regarding fatalities should be cleared with the Incident Commander and/or an organizational administrator prior to submission of the ICS 209.
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Block Number	Block Title	Instructions
32 (continued)	A. # This Reporting Period	Enter the total number of responders impacted in each category for this reporting period (since the previous ICS 209 was submitted).
	B. Total # to Date	<ul style="list-style-type: none"> Enter the total number of individuals impacted in each category for the entire duration of the incident. This is a cumulative total number that should be adjusted each reporting period.
	C. Indicate Number of Responders Below	<ul style="list-style-type: none"> For lines 32D–M below, enter the number of responders relevant for each category. Responders are those personnel included as part of Unified Command partnerships and those organizations and agencies assisting and cooperating with response efforts.
	D. Fatalities	<ul style="list-style-type: none"> Enter the number of confirmed responder fatalities. See information in introductory instructions ("Distribution") and for Block 32 regarding sensitive handling of fatality information.

E. With Injuries/Illness	<ul style="list-style-type: none"> Enter the number of incident responders with serious injuries or illnesses due to the incident. For responders, serious injuries or illness are typically those in which the person is unable to continue to perform in his or her incident assignment, but the authority having jurisdiction may have additional guidelines on reporting requirements in this area.
F. Trapped/In Need Of Rescue	Enter the number of incident responders who are in trapped or in need of rescue due to the incident.
G. Missing	Enter the number of incident responders who are missing due to incident conditions.
H.	(BLANK; use however is appropriate.)
I. Sheltering in Place	Enter the number of responders who are sheltering in place due to the incident. Once responders become the victims, this needs to be noted in Block 33 or Block 47 and handled accordingly.
J.	(BLANK; use however is appropriate.)
L. Require Immunizations	Enter the number of responders who require immunizations due to the incident and/or as part of incident operations.
M. In Quarantine	Enter the number of responders who are in quarantine as a direct result of the incident and/or related to incident operations.
N. Total # Responders Affected	Enter sum totals for Columns 32A and 32B for Rows 32D–M.
33	<p>Life, Safety, and Health Status/Threat Remarks</p> <ul style="list-style-type: none"> Enter any details needed for Blocks 31, 32, and 34. Enter any specific comments regarding illness, injuries, fatalities, and threat management for this incident, such as whether estimates were used for numbers given in Block 31. This information should be reported as accurately as possible as a snapshot in time, as much of the information is subject to frequent change. Evacuation information can be very sensitive to local residents and officials. Be accurate in the assessment. Clearly note primary responsibility and contacts for any activities or information in Blocks 31, 32, and 34 that may be caused by the incident but that are being managed and/or reported by other parties. Provide additional explanation or information as relevant in Blocks 35, 36, 38, 40, 41, or in Remarks (Block 47).

Block Number	Block Title	Instructions
34	Life, Safety, and Health Threat Management	Note any details in Life, Safety, and Health Status/Threat Remarks (Block 33), and provide additional explanation or information as relevant in Blocks 35, 36, 38, 40, 41, or in Remarks (Block 47). Additional pages may be necessary for notes.
	A. Check if Active	Check any applicable blocks in 34C–P based on currently available information regarding incident activity and potential.
	B. Notes	Note any specific details, or include in Block 33.
	C. No Likely Threat	Check if there is no likely threat to life, health, and safety.
	D. Potential Future Threat	Check if there is a potential future threat to life, health, and safety.

E. Mass Notifications In Progress	<ul style="list-style-type: none"> Check if there are any mass notifications in progress regarding emergency situations, evacuations, shelter in place, or other public safety advisories related to this incident. These may include use of threat and alert systems such as the Emergency Alert System or a "reverse 911" system. Please indicate the areas where mass notifications have been completed (e.g., "mass notifications to ZIP codes 50201, 50014, 50010, 50011," or "notified all residents within a 5-mile radius of Gatlinburg").
F. Mass Notifications Completed	Check if actions referred to in Block 34E above have been completed.
G. No Evacuation(s) Imminent	Check if evacuations are not anticipated in the near future based on current information.
H. Planning for Evacuation	Check if evacuation planning is underway in relation to this incident.
I. Planning for Shelter-in-Place	Check if planning is underway for shelter-in-place activities related to this incident.
J. Evacuation(s) in Progress	Check if there are active evacuations in progress in relation to this incident.
K. Shelter-In-Place in Progress	Check if there are active shelter-in-place actions in progress in relation to this incident.
L. Repopulation in Progress	Check if there is an active repopulation in progress related to this incident.
M. Mass Immunization in Progress	Check if there is an active mass immunization in progress related to this incident.
N. Mass Immunization Complete	Check if a mass immunization effort has been completed in relation to this incident.
O. Quarantine in Progress	Check if there is an active quarantine in progress related to this incident.
P. Area Restriction in Effect	Check if there are any restrictions in effect, such as road or area closures, especially those noted in Block 28.

Block Number	Block Title	Instructions
35	Weather Concerns (synopsis of current and predicted weather; discuss related factors that may cause concern)	<ul style="list-style-type: none"> • Complete a short synopsis/discussion on significant weather factors that could cause concerns for the incident when relevant. • Include current and/or predicted weather factors, and the timeframe for predictions. • Include relevant factors such as: <ul style="list-style-type: none"> ◦ Wind speed (label units, such as mph) ◦ Wind direction (clarify and label where wind is coming from and going to in plain language – e.g., "from NNW," "from E," or "from SW"). ◦ Temperature (label units, such as F) ◦ Relative humidity (label %). ◦ Watches. ◦ Warnings. ◦ Tides. ◦ Currents. • Any other weather information relative to the incident, such as flooding, hurricanes, etc.
36	Projected Incident Activity, Potential, Movement, Escalation, or Spread and influencing factors during the next operational period and in 12-, 24-, 48-, and 72-hour timeframes 12 hours 24 hours 48 hours 72 hours Anticipated after 72 hours	<ul style="list-style-type: none"> • Provide an estimate (when it is possible to do so) of the direction/scope in which the incident is expected to spread, migrate, or expand during the next indicated operational period, or other factors that may cause activity changes. • Discuss incident potential relative to values at risk, or values to be protected (such as human life), and the potential changes to those as the incident changes. • Include an estimate of the acreage or area that will likely be affected. • If known, provide the above information in 12-, 24-, 48- and 72-hour timeframes, and any activity anticipated after 72 hours.
37	Strategic Objectives (define planned end-state for incident)	Briefly discuss the desired outcome for the incident based on currently available information. Note any high-level objectives and any possible strategic benefits as well (especially for planned events).

Block Number	Block Title	Instructions
ADDITIONAL INCIDENT DECISION SUPPORT INFORMATION (continued) (PAGE 3)		
38	<p>Current Incident Threat Summary and Risk Information in 12-, 24-, 48-, and 72-hour timeframes and beyond.</p> <p>Summarize primary incident threats to life, property, communities and community stability, residences, health care facilities, other critical infrastructure and key resources, commercial facilities, natural and environmental resources, cultural resources, and continuity of operations and/or business. Identify corresponding incident-related potential economic or cascading impacts.</p> <p>12 hours</p> <p>24 hours</p> <p>48 hours</p> <p>72 hours</p> <p>Anticipated after 72 hours</p>	<p>Summarize major or significant threats due to incident activity based on currently available information. Include a breakdown of threats in terms of 12-, 24-, 48-, and 72-hour timeframes.</p>

Block Number	Block Title	Instructions
39	<p>Critical Resource Needs in 12-, 24-, 48- and 72-hour timeframes and beyond to meet critical incident objectives. List resource category, kind, and/or type, and amount needed, in priority order:</p> <p>12 hours</p> <p>24 hours</p> <p>48 hours</p> <p>72 hours</p> <p>Anticipated after 72 hours.</p>	<ul style="list-style-type: none"> List the specific critical resources and numbers needed. In order of priority. <i>Be specific as to the need.</i> Use plain language and common terminology for resources, and indicate resource category, kind, and type (if available or known) to facilitate incident support. If critical resources are listed in this block, there should be corresponding orders placed for them through appropriate resource ordering channels. Provide critical resource needs in 12-, 24-, 48- and 72-hour increments. List the most critical resources needed for each timeframe, if needs have been identified for each timeframe. Listing critical resources by the time they are needed gives incident support personnel a "heads up" for short-range planning, and assists the ordering process to ensure these resources will be in place when they are needed. More than one resource need may be listed for each timeframe. For example, a list could include: <ul style="list-style-type: none"> <u>24 hrs:</u> 3 Type 2 firefighting helicopters, 2 Type 1 Disaster Medical Assistance Teams <u>48 hrs:</u> Mobile Communications Unit (Law/Fire) <u>After 72 hrs:</u> 1 Type 2 Incident Management Team Documentation in the ICS 209 can help the incident obtain critical regional or national resources through outside support mechanisms including multiagency coordination systems and mutual aid. <ul style="list-style-type: none"> Information provided in other blocks on the ICS 209 can help to support the need for resources, including Blocks 28, 29, 31-38, and 40-42. Additional comments in the Remarks section (Block 47) can also help explain what the incident is requesting and why it is critical (for example, "Type 2 Incident Management Team is needed in three days to transition command when the current Type 2 Team times out"). Do not use this block for noncritical resources.
40	<p>Strategic Discussion: Explain the relation of overall strategy, constraints, and current available information to:</p> <p>1) critical resource needs identified above,</p> <p>2) the Incident Action Plan and management objectives and targets,</p> <p>3) anticipated results.</p>	<ul style="list-style-type: none"> Wording should be consistent with Block 39 to justify critical resource needs, which should relate to planned actions in the Incident Action Plan. Give a short assessment of the likelihood of meeting the incident management targets, given the current management strategy and currently known constraints. Identify when the chosen management strategy will succeed given the current constraints. Adjust the anticipated incident management completion target in Block 43 as needed based on this discussion. Explain major problems and concerns as indicated.

	Explain major problems and concerns such as operational challenges, incident management problems, and social, political, economic, or environmental concerns or impacts.	
Block Number	Block Title	Instruction
41	Planned Actions for Next Operational Period	<ul style="list-style-type: none"> • Provide a short summary of actions planned for the next operational period. • Examples: <ul style="list-style-type: none"> ○ "The current Incident Management Team will transition out to a replacement IMT." ○ "Continue to review operational/engineering plan to facilitate removal of the partially collapsed west bridge supports." ○ "Continue refining mapping of the recovery operations and damaged assets using GPS." ○ "Initiate removal of unauthorized food vendors."
42	Projected Final Incident Size/Area (use unit label - e.g., "sq mi")	<ul style="list-style-type: none"> • Enter an estimate of the total area likely to be involved or affected over the course of the incident. • Label the estimate of the total area or population involved, affected, or impacted with the relevant units such as acres, hectares, square miles, etc. • Note that total area involved may not be limited to geographic area (see previous discussion regarding incident definition, scope, operations, and objectives). Projected final size may involve a population rather than a geographic area.
43	Anticipated Incident Management Completion Date	<ul style="list-style-type: none"> • Enter the date (month/day/year) at which time it is expected that incident objectives will be met. This is often explained similar to incident containment or control, or the time at which the incident is expected to be closed or when significant incident support will be discontinued. • Avoid leaving this block blank if possible, as this is important information for managers.
44	Projected Significant Resource Demobilization Start Date	Enter the date (month/day/year) when initiation of significant resource demobilization is anticipated.
45	Estimated Incident Costs to Date	<ul style="list-style-type: none"> • Enter the estimated total incident costs to date for the entire incident based on currently available information. • Incident costs include estimates of all costs for the response, including all management and support activities per discipline, agency, or organizational guidance and policy. • This does not include damage assessment figures, as they are impacts from the incident and not response costs. • If costs decrease, explain in Remarks (Block 47). • If additional space is required, please add as an attachment.

46	Projected Final Incident Cost Estimate	<ul style="list-style-type: none">• Enter an estimate of the total costs for the incident once all costs have been processed based on current spending and projected incident potential, per discipline, agency, or organizational guidance and policy. This is often an estimate of daily costs combined with incident potential information.• This does not include damage assessment figures, as they are impacts from the incident and not response costs.• If additional space is required, please add as an attachment.
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Block Number	Block Title	Instructions
47	Remarks (or continuation of any blocks above – list block number in notation)	<ul style="list-style-type: none"> • Use this block to expand on information that has been entered in previous blocks, or to include other pertinent information that has not been previously addressed. • List the block number for any information continued from a previous block. • Additional information may include more detailed weather information, specifics on injuries or fatalities, threats to critical infrastructure or other resources, more detailed evacuation site locations and number of evacuated, information or details regarding incident cause, etc. • For Complexes that include multiple incidents, list all sub-incident(s) included in the Complex. • List jurisdictional or ownership breakdowns if needed when an incident is in more than one jurisdiction and/or ownership area. Breakdown may be: <ul style="list-style-type: none"> ◦ By size (e.g., 35 acres in City of Gatlinburg, 250 acres in Great Smoky Mountains), and/or ◦ By geography (e.g., incident area on the west side of the river is in jurisdiction of City of Minneapolis, area on east side of river is City of St. Paul jurisdiction, river is joint jurisdiction with USACE). • Explain any reasons for incident size reductions or adjustments (e.g., reduction in acreage due to more accurate mapping) • This section can also be used to list any additional information about the incident that may be needed by incident support mechanisms outside the incident itself. This may be basic information needed through multiagency coordination systems or public information systems (e.g., a public information phone number for the incident, or the incident Web site address). • Attach additional pages if it is necessary to include additional comments in the Remarks section.
INCIDENT RESOURCE COMMITMENT SUMMARY (PAGE 4)		
<ul style="list-style-type: none"> • This last/fourth page of the ICS 209 can be copied and used if needed to accommodate additional resources, agencies, or organizations. Write the actual page number on the pages as they are used. • Include only resources that have been assigned to the incident and that have arrived and/or been checked in to the incident. Do not include resources that have been ordered but have not yet arrived. <p><u>For summarizing</u></p> <ul style="list-style-type: none"> • When there are large numbers of responders, it may be helpful to group agencies or organizations together. Use the approach that works best for the multiagency coordination system applicable to the incident. For example: <ul style="list-style-type: none"> ◦ Group State, local, county, city, or Federal responders together under such headings, or ◦ Group resources from one jurisdiction together and list only individual jurisdictions (e.g., list the public works, police, and fire department resources for a city under that city's name). • On a large incident, it may also be helpful to group similar categories, kinds, or types of resources together for this summary. 		

Block Number	Block Title	Instructions
48	Agency or Organization	<ul style="list-style-type: none"> List the agencies or organizations contributing resources to the incident, as responders, through mutual aid agreements, etc. List agencies or organizations using clear language so readers who may not be from the discipline or host jurisdiction can understand the information. Agencies or organizations may be listed individually or in groups. When resources are grouped together, individual agencies or organizations may be listed below in Block 53. Indicate in the rows under Block 49 how many resources are assigned to the incident under each resource identified. <ul style="list-style-type: none"> These can listed with the number of resources on the top of the box, and the number of personnel associated with the resources on the bottom half of the box. For example: <ul style="list-style-type: none"> Resource: Type 2 Helicopters 3/8 (indicates 3 aircraft, 8 personnel) Resource: Type 1 Decontamination Unit 1/3 (indicates 1 unit, 3 personnel) Indicate in the rows under Block 51 the total number of personnel assigned for each agency listed under Block 48, including both individual overhead and those associated with other resources such as fire engines, decontamination units, etc.
49	Resources (summarize resources by category kind, and/or type; show # of resources on top ½ of box, show # of personnel associated with resource on bottom ½ of box)	<ul style="list-style-type: none"> List resources using clear language when possible – so ICS 209 readers who may not be from the discipline or host jurisdiction can understand the information. <ul style="list-style-type: none"> Examples: Type 1 Fire Engines, Type 4 Helicopters Enter total numbers in columns for each resource by agency, organization, or grouping in the proper blocks. <ul style="list-style-type: none"> These can listed with the number of resources on the top of the box, and the number of personnel associated with the resources on the bottom half of the box. For example: <ul style="list-style-type: none"> Resource: Type 2 Helicopters 3/8 (indicates 3 aircraft, 8 personnel) Resource: Type 1 Decontamination Unit 1/3 (indicates 1 unit, 3 personnel) NOTE: One option is to group similar resources together when it is sensible to do so for the summary. <ul style="list-style-type: none"> For example, do not list every type of fire engine – rather, it may be advisable to list two generalized types of engines, such as 'structure fire engines' and 'wildland fire engines' in separate columns with totals for each. NOTE: It is not advisable to list individual overhead personnel individually in the resource section, especially as this form is intended as a summary. These personnel should be included in the Total Personnel sums in Block 51.
50	Additional Personnel not assigned to a resource	List the number of <i>additional</i> individuals (or overhead) that are not assigned to a specific resource by agency or organization.

51	Total Personnel (includes those associated with resources – e.g., aircraft or engines, – and individual overhead)	<ul style="list-style-type: none"> • Enter the total personnel for each agency, organization, or grouping in the Total Personnel column. • WARNING: Do not simply add the numbers across! • The number of Total Personnel for each row should include <u>both</u>: <ul style="list-style-type: none"> ◦ The total number of personnel assigned to each of the resources listed in Block 49, and ◦ The total number of additional individual overhead personnel from each agency, organization, or group listed in Block 50.
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Block Number	Block Title	Instructions
52	Total Resources	Include the sum total of resources for each column, including the total for the column under Blocks 49, 50, and 51. This should include the total number of resources in Block 49, as personnel totals will be counted under Block 51.
53	Additional Cooperating and Assisting Organizations Not Listed Above	<ul style="list-style-type: none"> • List all agencies and organizations that are not directly involved in the incident, but are providing support. • Examples may include ambulance services, Red Cross, DHS, utility companies, etc. • Do not repeat any resources counted in Blocks 48–52, unless explanations are needed for groupings created under Block 48 (Agency or Organization).

9. Prepared by: Name: _____		Position/Title: _____	Signature: _____
ICS 210	Date/Time: _____		

**ICS 210
Resource Status Change**

Purpose. The Resource Status Change (ICS 210) is used by the Incident Communications Center Manager to record status change information received on resources assigned to the incident. This information could be transmitted with a General Message (ICS 213). The form could also be used by Operations as a worksheet to track entry, etc.

Preparation. The ICS 210 is completed by radio/telephone operators who receive status change information from individual resources, Task Forces, Strike Teams, and Division/Group Supervisors. Status information could also be reported by Staging Area and Helibase Managers and fixed-wing facilities.

Distribution. The ICS 210 is maintained by the Communications Unit and copied to Resources Unit and filed by Documentation Unit.

Notes:

- The ICS 210 is essentially a message form that can be used to update Resource Status Cards or Task Cards (ICS 212) for incident-level resource management.
- If additional pages are needed, use a blank (ICS 210) and repaginate as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Resource Number	Enter the resource identification (ID) number (this may be a letter and number combination) assigned by either the sending unit or the incident.
4	New Status (Available, Assigned, Out of Service)	Indicate the current status of the resource. <ul style="list-style-type: none"> • Available – Indicates resource is available for incident use immediately. • Assigned – Indicates resource is checked in and assigned a work task on the incident. • Out of Service – Indicates resource is assigned to the incident but unable to respond for mechanical, rest, or personnel reasons. If space permits, indicate the estimated time of return (ETR). It may be useful to indicate the reason a resource is out of service (e.g., "O/S – Mech" for mechanical issues, "O/S – Rest" for off shift, or "O/S – Pers" for personnel issues).
5	From (Assignment and Status)	Indicate the current location of the resource (where it came from) and the status. When more than one Division, Staging Area, or Camp is used, identify the specific location (e.g., Division A, Staging Area, Incident Command Post, Western Camp).
6	To (Assignment and Status)	Indicate the assigned incident location of the resource and status. When more than one Division, Staging Area, or Camp is used, identify the specific location.
7	Time and Date of Change	Enter the time and location of the status change (24-hour clock). Enter the date as well if relevant (e.g., out of service).
8	Comments	Enter any special information provided by the resource or dispatch center. This may include details about why a resource is out of service, or individual identifying designators (IDs) of Strike Teams and Task Forces.

9	Prepared by <ul style="list-style-type: none">• Name• Position/Title• Signature• Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).
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INCIDENT CHECK-IN LIST (ICS 211)

1. Incident Name:		2. Incident Number:		3. Check-In Location (complete all that apply): <input type="checkbox"/> Base <input type="checkbox"/> Staging Area <input type="checkbox"/> ICP <input type="checkbox"/> Helibase <input type="checkbox"/> Other				4. Start Date/Time: Date: Time:								
Check-In Information (use reverse of form for remarks or comments)																
5. List single resource personnel (overhead) by agency and name, OR list resources by the following format:						6. Order Request #	7. Date/Time Check-In	8. Leader's Name	9. Total Number of Personnel	10. Incident Contact Information	11. Home Unit or Agency	12. Departure Point, Date and Time	13. Method of Travel	14. Incident Assignment	15. Other Qualifications	16. Data Provided to Resources Unit
State	Agency	Category	Kind	Type	Resource Name or Identifier											



ICS 211	17. Prepared by: Name: _____ Position/Title: _____ Signature: _____ Date/Time: _____
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CONFIDENTIAL

**ICS 211
Incident Check-In List**

Purpose. Personnel and equipment arriving at the incident can check in at various incident locations. Check-in consists of reporting specific information, which is recorded on the Check-In List (ICS 211). The ICS 211 serves several purposes: as it: (1) records arrival times at the incident of all overhead personnel and equipment, (2) records the initial location of personnel and equipment to facilitate subsequent assignments, and (3) supports demobilization by recording the home base, method of travel, etc., for resources checked in.

Preparation. The ICS 211 is initiated at a number of incident locations including: Staging Areas, Bases, and Incident Command Post (ICP). Preparation may be completed by: (1) overhead at these locations, who record the information and give it to the Resources Unit as soon as possible, (2) the Incident Communications Center Manager located in the Communications Center, who records the information and gives it to the Resources Unit as soon as possible, (3) a recorder from the Resources Unit during check-in to the ICP. As an option, the ICS 211 can be printed on colored paper to match the designated Resource Status Card (ICS 219) colors. The purpose of this is to aid the process of completing a large volume of ICS 219s. The ICS 219 colors are:

- 219-1: Header Card – Gray (used only as label cards for T-Card racks)
- 219-2: Crew/Team Card – Green
- 219-3: Engine Card – Red
- 219-4: Helicopter Card – Blue
- 219-5: Personnel Card – White
- 219-6: Fixed-Wing Card – Orange
- 219-7: Equipment Card – Yellow
- 219-8: Miscellaneous Equipment/Task Force Card – Tan
- 219-10: Generic Card – Light Purple

Distribution. ICS 211s, which are completed by personnel at the various check-in locations, are provided to the Resources Unit, Demobilization Unit, and Finance/Administration Section. The Resources Unit maintains a master list of all equipment and personnel that have reported to the incident.

Notes:

- Also available as 8½ x 14 (legal size) or 11 x 17 chart.
- Use reverse side of form for remarks or comments.
- If additional pages are needed for any form page, use a blank ICS 211 and repage as needed.
- Contact information for sender and receiver can be added for communications purposes to confirm resource orders. Refer to 213RR example (Appendix B).

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Incident Number	Enter the number assigned to the incident.
3	Check-In Location <input type="checkbox"/> Base <input type="checkbox"/> Staging Area <input type="checkbox"/> ICP <input type="checkbox"/> Helibase <input type="checkbox"/> Other	Check appropriate box and enter the check-in location for the incident. Indicate specific information regarding the locations under each checkbox. ICP is for Incident Command Post. Other may include:

4	Start Date/Time • Date • Time	Enter the date (month/day/year) and time (using the 24-hour clock) that the form was started.
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Block Number	Block Title	Instructions
	Check-In Information	Self explanatory.
5	List single resource personnel (overhead) by agency and name, OR list resources by the following format	Enter the following information for resources: OPTIONAL: Indicate if resource is a single resource versus part of Strike Team or Task Force. Fields can be left blank if not necessary.
	• State	Use this section to list the home State for the resource.
	• Agency	Use this section to list agency name (or designator), and individual names for all single resource personnel (e.g., ORC, ARL, NYPD).
	• Category	Use this section to list the resource category based on NIMS, discipline, or jurisdiction guidance.
	• Kind	Use this section to list the resource kind based on NIMS, discipline, or jurisdiction guidance.
	• Type	Use this section to list the resource type based on NIMS, discipline, or jurisdiction guidance.
	• Resource Name or Identifier	Use this section to enter the resource name or unique identifier. If it is a Strike Team or a Task Force, list the unique Strike Team or Task Force identifier (if used) on a single line with the component resources of the Strike Team or Task Force listed on the following lines. For example, for an Engine Strike Team with the call sign "KLT459" show "KLT459" in this box and then in the next five rows, list the unique identifier for the five engines assigned to the Strike Team.
	• ST or TF	Use ST or TF to indicate whether the resource is part of a Strike Team or Task Force. See above for additional instructions.
6	Order Request #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline, since several incident numbers may be used for the same incident.
7	Date/Time Check-In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
8	Leader's Name	• For equipment, enter the operator's name. • Enter the Strike Team or Task Force leader's name. • Leave blank for single resource personnel (overhead).
9	Total Number of Personnel	Enter total number of personnel associated with the resource. Include leaders.
10	Incident Contact Information	Enter available contact information (e.g., radio frequency, cell phone number, etc.) for the incident.
11	Home Unit or Agency	Enter the home unit or agency to which the resource or individual is normally assigned (may not be departure location).
12	Departure Point, Date and Time	Enter the location from which the resource or individual departed for this incident. Enter the departure time using the 24-hour clock.
13	Method of Travel	Enter the means of travel the individual used to bring himself/herself to the incident (e.g., bus, truck, engine, personal vehicle, etc.).

14	Incident Assignment	Enter the incident assignment at time of dispatch
15	Other Qualifications	Enter additional duties (ICS positions) pertinent to the incident that the resource/individual is qualified to perform. Note that resources should not be reassigned on the incident without going through the established ordering process. This data may be useful when resources are demobilized and remobilized for another incident.

Block Number	Block Title	Instructions
16	Data Provided to Resources Unit	Enter the date and time that the information pertaining to that entry was transmitted to the Resources Unit, and the initials of the person who transmitted the information.
17	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

GENERAL MESSAGE (ICS 213)

1. Incident Name (Optional):		
2. To (Name and Position):		
3. From (Name and Position):		
4. Subject:	5. Date:	6. Time
7. Message:		
8. Approved by: Name: _____ Signature: _____ Position/Title: _____		
9. Reply:		

10. Replied by: Name: _____	Position/Title: _____	Signature: _____
ICS 213	Date/Time: _____	

**ICS 213
General Message**

Purpose. The General Message (ICS 213) is used by the incident dispatchers to record incoming messages that cannot be orally transmitted to the intended recipients. The ICS 213 is also used by the Incident Command Post and other incident personnel to transmit messages (e.g., resource order, incident name change, other ICS coordination issues, etc.) to the Incident Communications Center for transmission via radio or telephone to the addressee. This form is used to send any message or notification to incident personnel that requires hard-copy delivery.

Preparation. The ICS 213 may be initiated by incident dispatchers and any other personnel on an incident.

Distribution. Upon completion, the ICS 213 may be delivered to the addressee and/or delivered to the Incident Communication Center for transmission.

Notes:

- The ICS 213 is a three-part form typically using carbon paper. The sender will complete Part 1 of the form and send Parts 2 and 3 to the recipient. The recipient will complete Part 2 and return Part 3 to the sender.
- A copy of the ICS 213 should be sent to and maintained within the Documentation Unit.
- Contact information for the sender and receiver can be added for communications purposes to confirm resource orders. Refer to 213RR example (Appendix B).

Block Number	Block Title	Instructions
1	Incident Name (Optional)	Enter the name assigned to the incident. This block is optional.
2	To (Name and Position)	Enter the name and position the General Message is intended for. For all individuals, use at least the first initial and last name. For Unified Command, include agency names.
3	From (Name and Position)	Enter the name and position of the individual sending the General Message. For all individuals, use at least the first initial and last name. For Unified Command, include agency names.
4	Subject	Enter the subject of the message.
5	Date	Enter the date (month/day/year) of the message.
6	Time	Enter the time (using the 24-hour clock) of the message.
7	Message	Enter the content of the message. Try to be as concise as possible.
8	Approved by • Name • Signature • Position/Title	Enter the name, signature, and ICS position/title of the person approving the message.
9	Reply	The intended recipient will enter a reply to the message and return it to the originator.
10	Replied by • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position/title, and signature of the person replying to the message. Enter date (month/day/year) and time prepared (24-hour clock).

RESOURCE REQUEST MESSAGE (ICS 213 RR)

1. Incident Name:			2. Date/Time		3. Resource Request Number:		
Requestor	4. Order (Use additional forms when requesting different resource sources of supply.):						
	Qty	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Arrival Date and Time		Cost
					Requested	Estimated	
5. Requested Delivery/Reporting Location:							
6. Suitable Substitutes and/or Suggested Sources: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
7. Requested by Name/Position:				8. Priority: Urgent Routine Low		9. Section Chief Approval:	
Logistics	10. Logistics Order Number:				11. Supplier Phone/Fax/Email:		
	12. Name of Supplier/POC:						
	13. Notes:						
	14. Approval Signature of Auth Logistics Rep: <input type="checkbox"/> <input type="checkbox"/>				15. Date/Time:		
16. Order placed by (check box): SPUL PROC							
Finance	17. Reply/Comments from Finance:						

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18. Finance Section Signature:	19. Date/Time:
ICS 213 RR, Page 1	

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8. Prepared by: Name: _____	Position/Title: _____	Signature: _____
ICS 214, Page 1	Date/Time: _____	

8. Prepared by: Name: _____	Position/Title: _____	Signature: _____
ICS 214, Page 2	Date/Time: _____	

**ICS 214
Activity Log**

Purpose. The Activity Log (ICS 214) records details of notable activities at any ICS level, including single resources, equipment, Task Forces, etc. These logs provide basic incident activity documentation, and a reference for any after-action report.

Preparation. An ICS 214 can be initiated and maintained by personnel in various ICS positions as it is needed or appropriate. Personnel should document how relevant incident activities are occurring and progressing, or any notable events or communications.

Distribution. Completed ICS 214s are submitted to supervisors, who forward them to the Documentation Unit. All completed original forms must be given to the Documentation Unit, which maintains a file of all ICS 214s. It is recommended that individuals retain a copy for their own records.

Notes:

- The ICS 214 can be printed as a two-sided form.
- Use additional copies or continuation sheets as needed, and indicate pagination as used.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none"> • Date and Time From • Date and Time To 	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Name	Enter the title of the organizational unit or resource designator (e.g., Facilities Unit, Safety Officer, Strike Team).
4	ICS Position	Enter the name and ICS position of the individual in charge of the Unit.
5	Home Agency (and Unit)	Enter the home agency of the individual completing the ICS 214. Enter a unit designator if utilized by the jurisdiction or discipline.
6	Resources Assigned	Enter the following information for resources assigned:
	• Name	Use this section to enter the resource's name. For all individuals use at least the first initial and last name. Cell phone number for the individual can be added as an option.
	• ICS Position	Use this section to enter the resource's ICS position (e.g., Finance Section Chief).
7	• Home Agency (and Unit)	Use this section to enter the resource's home agency and/or unit (e.g., Des Moines Public Works Department, Water Management Unit).
	Activity Log <ul style="list-style-type: none"> • Date/Time • Notable Activities 	<ul style="list-style-type: none"> • Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date as well if the operational period covers more than one day. • Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, etc. • This block can also be used to track personal work habits by adding columns such as "Action Required," "Delegated To," "Status," etc.

8	Prepared by <ul style="list-style-type: none">• Name• Position/Title• Signature• Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).
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OPERATIONAL PLANNING WORKSHEET (ICS 215)

1. Incident Name:					2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____											
3. Branch	4. Division, Group, or Other	5. Work Assignment & Special Instructions	6. Resources										7. Overhead Position(s)	8. Special Equipment & Supplies	9. Reporting Location	10. Requested Arrival Time
			Req.	Have	Need											
			Req.													
			Have													
			Need													
			Req.													
			Have													
			Need													
			Req.													
			Have													
			Need													
			Req.													
			Have													
			Need													
		11. Total Resources Required														
		12. Total Resources Have on Hand														
													14. Prepared by: Name: _____			



ICS 215	13. Total Resources Need to Order																		Position/Title: _____ Signature: _____ Date/Time: _____

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**ICS 215
Operational Planning Worksheet**

Purpose. The Operational Planning Worksheet (ICS 215) communicates the decisions made by the Operations Section Chief during the Tactics Meeting concerning resource assignments and needs for the next operational period. The ICS 215 is used by the Resources Unit to complete the Assignment Lists (ICS 204) and by the Logistics Section Chief for ordering resources for the incident.

Preparation. The ICS 215 is initiated by the Operations Section Chief and often involves logistics personnel, the Resources Unit, and the Safety Officer. The form is shared with the rest of the Command and General Staffs during the Planning Meeting. It may be useful in some disciplines or jurisdictions to prefill ICS 215 copies prior to incidents.

Distribution. When the Branch, Division, or Group work assignments and accompanying resource allocations are agreed upon, the form is distributed to the Resources Unit to assist in the preparation of the ICS 204. The Logistics Section will use a copy of this worksheet for preparing requests for resources required for the next operational period.

Notes:

- This worksheet can be made into a wall mount.
- Also available as 8 1/2 x 11 (legal size) and 11 x 17 chart.
- If additional pages are needed, use a blank ICS 215 and repaginate as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Branch	Enter the Branch of the work assignment for the resources.
4	Division, Group, or Other	Enter the Division, Group, or other location (e.g., Staging Area) of the work assignment for the resources.
5	Work Assignment & Special Instructions	Enter the specific work assignments given to each of the Divisions/Groups and any special instructions, as required.
6	Resources	Complete resource headings for category, kind, and type as appropriate for the incident. The use of a slash indicates a single resource in the upper portion of the slash and a Strike Team or Task Force in the bottom portion of the slash.
	• Required	Enter, for the appropriate resources, the number of resources by type (engine, squad car, Advanced Life Support ambulance, etc.) required to perform the work assignment.
	• Have	Enter, for the appropriate resources, the number of resources by type (engines, crew, etc.) available to perform the work assignment.
	• Need	Enter the number of resources needed by subtracting the number in the "Have" row from the number in the "Required" row.
7	Overhead Position(s)	List any supervisory and non-supervisory ICS position(s) not directly assigned to a previously identified resource (e.g., Division/Group Supervisor, Assistant Safety Officer, Technical Specialist, etc.).
8	Special Equipment & Supplies	List special equipment and supplies, including aviation support, used or needed. This may be a useful place to monitor span of control.
9	Reporting Location	Enter the specific location where the resources are to report (Staging Area location at incident, etc.).

10	Requested Arrival Time	Enter the time (24-hour clock) that resources are requested to arrive at the reporting location.
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Block Number	Block Title	Instructions
11	Total Resources Required	Enter the total number of resources required by category/kind/type as preferred (e.g., engine, squad car, ALS ambulance, etc.). A slash can be used again to indicate total single resources in the upper portion of the slash and total Strike Teams/ Task Forces in the bottom portion of the slash.
12	Total Resources Have on Hand	Enter the total number of resources on hand that are assigned to the incident for incident use. A slash can be used again to indicate total single resources in the upper portion of the slash and total Strike Teams/Task Forces in the bottom portion of the slash.
13	Total Resources Need To Order	Enter the total number of resources needed. A slash can be used again to indicate total single resources in the upper portion of the slash and total Strike Teams/Task Forces in the bottom portion of the slash.
14	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

8. Prepared by (Safety Officer): Name: _____ Signature: _____	
Prepared by (Operations Section Chief): Name: _____ Signature: _____	
ICS 215A	Date/Time: _____

**ICS 215A
Incident Action Plan Safety Analysis**

Purpose. The purpose of the Incident Action Plan Safety Analysis (ICS 215A) is to aid the Safety Officer in completing an operational risk assessment to prioritize hazards, safety, and health issues, and to develop appropriate controls. This worksheet addresses communications challenges between planning and operations, and is best utilized in the planning phase and for Operations Section briefings.

Preparation. The ICS 215A is typically prepared by the Safety Officer during the incident action planning cycle. When the Operations Section Chief is preparing for the tactics meeting, the Safety Officer collaborates with the Operations Section Chief to complete the Incident Action Plan Safety Analysis. This worksheet is closely linked to the Operational Planning Worksheet (ICS 215). Incident areas or regions are listed along with associated hazards and risks. For those assignments involving risks and hazards, mitigations or controls should be developed to safeguard responders, and appropriate incident personnel should be briefed on the hazards, mitigations, and related measures. Use additional sheets as needed.

Distribution. When the safety analysis is completed, the form is distributed to the Resources Unit to help prepare the Operations Section briefing. All completed original forms must be given to the Documentation Unit.

Notes:

- This worksheet can be made into a wall mount, and can be part of the IAP.
- If additional pages are needed, use a blank ICS 215A and reformat as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Incident Number	Enter the number assigned to the incident.
3	Date/Time Prepared	Enter date (month/day/year) and time (using the 24-hour clock) prepared.
4	Operational Period • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (24-hour clock) and end date and time for the operational period to which the form applies.
5	Incident Area	Enter the incident areas where personnel or resources are likely to encounter risks. This may be specified as a Branch, Division, or Group.
6	Hazards/Risks	List the types of hazards and/or risks likely to be encountered by personnel or resources at the incident area relevant to the work assignment.
7	Mitigations	List actions taken to reduce risk for each hazard indicated (e.g., specify personal protective equipment or use of a buddy system or escape routes).
8	Prepared by (Safety Officer and Operations Section Chief) • Name • Signature • Date/Time	Enter the name of both the Safety Officer and the Operations Section Chief, who should collaborate on form preparation. Enter date (month/day/year) and time (24-hour clock) reviewed.

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ICS 218
Support Vehicle/Equipment Inventory

Purpose. The Support Vehicle/Equipment Inventory (ICS 218) provides an inventory of all transportation and support vehicles and equipment assigned to the incident. The information is used by the Ground Support Unit to maintain a record of the types and locations of vehicles and equipment on the incident. The Resources Unit uses the information to initiate and maintain status/resource information.

Preparation. The ICS 218 is prepared by Ground Support Unit personnel at intervals specified by the Ground Support Unit Leader.

Distribution. Initial inventory information recorded on the form should be given to the Resources Unit. Subsequent changes to the status or location of transportation and support vehicles and equipment should be provided to the Resources Unit immediately.

Notes:

- If additional pages are needed, use a blank ICS 218 and renumber as needed.
- Use a legal-size (8 1/2 x 14) legal size form (11 x 17) form.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Incident Number	Enter the number assigned to the incident.
3	Date/Time Prepared	Enter the date (month/day/year) and time (using the 24-hour clock) the form is prepared.
4	Vehicle/Equipment Category	Enter the specific vehicle or equipment category (e.g., buses, generators, dozers, pickups/sedans, rental cars, etc.). Use a separate sheet for each vehicle or equipment category.
5	Vehicle/Equipment Information	Record the following information:
	Order Request Number	Enter the order request number for the resource as used by the jurisdiction or discipline, or the relevant EMAC order request number.
	Incident Identification Number	Enter any special incident identification numbers or agency radio identifier assigned to the piece of equipment used only during the incident, if this system is used (e.g., "Decontamination Unit 2" or "Water Tender 14").
	Vehicle or Equipment Classification	Enter the specific vehicle or equipment classification (e.g., bus, backhoe, Type 2 engine, etc.) as relevant.
	Vehicle or Equipment Make	Enter the vehicle or equipment manufacturer name (e.g., "GMC International").
	Category/Kind/Type, Capacity, or Size	Enter the vehicle or equipment category/kind/type, capacity, or size (e.g., 30-person bus, 3/4-ton truck, 50 kW generator).
	Vehicle or Equipment Features	Indicate any vehicle or equipment features such as 2WD, 4WD, towing capability, number of axles, heavy-duty tires, high clearance, automatic vehicle locator (AVL), etc.
	Agency or Owner	Enter the name of the agency or owner of the vehicle or equipment.
	Operator Name or Contact	Enter the operator name and/or contact information (cell phone, radio frequency, etc.).
	Vehicle License or Identification Number	Enter the license plate number or another identification number (such as a serial or rig number) of the vehicle or equipment.

Incident Assignment	Enter where the vehicle or equipment will be located at the incident and its function (use abbreviations per discipline or jurisdiction).
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Block Number	Block Title	Instructions
5 (continued)	Incident Start Date and Time	Indicate start date (month/day/year) and time (using the 24-hour clock) for driver or for equipment as may be relevant.
	Incident Release Date and Time	Enter the date (month/day/year) and time (using the 24-hour clock) the vehicle or equipment is released from the incident.
6	Prepared by <ul style="list-style-type: none"> • Name • Position/Title • Signature 	Enter the name, ICS position/title, and signature of the person preparing the form.

ICS 219 Resource Status Card (T-Card)

Purpose. Resource Status Cards (ICS 219) are also known as "T-Cards," and are used by the Resources Unit to record status and location information on resources, transportation, and support vehicles and personnel. These cards provide a visual display of the status and location of resources assigned to the incident.

Preparation. Information to be placed on the cards may be obtained from several sources including, but not limited to:

- Incident Briefing (ICS 201)
- Incident Check-In List (ICS 211)
- General Message (ICS 213)
- Agency-supplied information or electronic resource management systems.

Distribution. ICS 219s are displayed in resource status or "T-Card" racks where they can be easily viewed, retrieved, updated, and rearranged. The Resources Unit typically maintains cards for resources assigned to an incident until demobilization. At demobilization, all cards should be turned in to the Documentation Unit.

Notes. There are eight different status cards (see list below) and a header card, to be printed front-to-back on cardstock. Each card is printed on a different color of cardstock and used for a different resource category/kind/type. The format and content of information on each card varies depending upon the intended use of the card.

- 219-1: Header Card – Gray (used only as label cards for T-Card racks)
- 219-2: Crew/Team Card – Green
- 219-3: Engine Card – Rose
- 219-4: Helicopter Card – Blue
- 219-5: Personnel Card – White
- 219-6: Fixed-Wing Card – Orange
- 219-7: Equipment Card – Yellow
- 219-8: Miscellaneous Equipment/Task Force Card – Tan
- 219-10: Generic Card – Light Purple

Acronyms. Abbreviations utilized on the cards are listed below

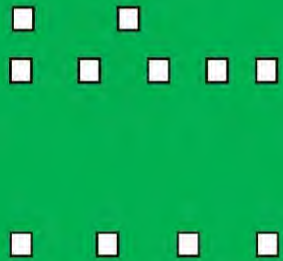
- AOV: Agency-owned vehicle
- ETA: Estimated time of arrival
- ETD: Estimated time of departure
- ETR: Estimated time of return
- O/S Mech: Out-of-service for mechanical reasons
- O/S Pers: Out-of-service for personnel reasons
- O/S Rest: Out-of-service for rest/recuperation purposes/guidelines, or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft
- POV: Privately owned vehicle

ICS 219-1: Header Card

Block Title	Instructions
Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #
<i>Front</i>			
Date/Time Checked In:			
Leader Name:			
Primary Contact Information:			
Crew/Team ID #(s) or Name(s):			
Manifest:		Total Weight:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Method of Travel to Incident:			
<input type="checkbox"/> AOV <input type="checkbox"/> POV <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other			
Home Base:			
Departure Point:			
ETD:		ETA:	
Transportation Needs at Incident:			
<input type="checkbox"/> Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other			
Date/Time Ordered:			
Remarks:			
Prepared by:			
Date/Time:			

ICS 219-2 CREW/TEAM (GREEN)



ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #

Back

Incident Location: Time:

Status:
 Assigned O/S Rest O/S Pers
 Available O/S Mech ETR. _____

Notes:

Incident Location: Time:

Status:
 Assigned O/S Rest O/S Pers
 Available O/S Mech ETR. _____

Notes:

Incident Location: Time:

Status:
 Assigned O/S Rest O/S Pers
 Available O/S Mech ETR. _____

Notes:

Incident Location: Time:

Status:
 Assigned O/S Rest O/S Pers
 Available O/S Mech ETR. _____

Notes:

Prepared by:

Date/Time:

ICS 219-2 CREW/TEAM (GREEN)

ICS 219-2: Crew/Team Card

Block Title	Instructions
ST/Unit	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the crew/team. Include leaders.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline, since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYPD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource's name or unique identifier (e.g., 13, Bluewater, Utility 32).
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Leader Name	Enter resource leader's name (use at least the first initial and last name).
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code and any satellite phone-specifics.
Crew/Team ID #(s) or Name(s)	Provide the identifier number(s) or name(s) for this crew/team (e.g., Air Monitoring Team 2, Entry Team 3).
Manifest <input type="checkbox"/> Yes <input type="checkbox"/> No	Use this section to enter whether or not the resource or personnel has a manifest. If they do, indicate the manifest number.
Total Weight	Enter the total weight for the crew/team. This information is necessary when the crew/team are transported by charter air.
Method of Travel to Incident <input type="checkbox"/> AOV <input type="checkbox"/> POV <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other	Check the box(es) for the appropriate method(s) of travel the individual used to bring himself/herself to the incident. AOV is "agency-owned vehicle." POV is "privately owned vehicle."
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the crew/team's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the crew/team's estimated time of arrival (using the 24-hour clock) at the incident.

Block Title	Instructions
Transportation Needs at Incident <input type="checkbox"/> Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other	Check the box(es) for the appropriate method(s) of transportation at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the crew/team was ordered to the incident.
Remarks	Enter any additional information pertaining to the crew/team.
BACK OF FORM	
Incident Location	Enter the location of the crew/team.
Time	Enter the time (24-hour clock) the crew/team reported to this location.
Status <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____	Enter the crew/team's current status: <ul style="list-style-type: none"> • Assigned – Assigned to the incident • O/S Rest – Out-of-service for rest/recuperation purposes/guidelines, or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft • O/S Pers – Out-of-service for personnel reasons • Available – Available to be assigned to the incident • O/S Mech – Out-of-service for mechanical reasons • ETR – Estimated time of return
Notes	Enter any additional information pertaining to the crew/team's current location or status.
Prepared by	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).
Date/Time	

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #
<i>Front</i>			
Date/Time Checked In:			
Leader Name:			
Primary Contact Information:			
Resource ID #(s) or Name(s):			
Home Base:			
Departure Point:			
ETD:		ETA:	
Date/Time Ordered:			
Remarks:			

Prepared by:
Date/Time:
ICS 219-3 ENGINE (ROSE)

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #

Back

Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		

Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		

Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		

Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		

Prepared by:
Date/Time:
ICS 219-3 ENGINE (ROSE)

(CS 219-3: Engine Card)

Block Title	Instructions
ST/Unit:	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include leaders.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYPD).
Cal/Kind/Type	Enter the category/kind/type based on NIMS discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier (e.g., 13, Bluewater, Utility 32).
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Leader Name	Enter resource leader's name (use at least the first initial and last name).
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code & any satellite phone specifics.
Resource ID #(s) or Name(s)	Provide the identifier number(s) or name(s) for the resource(s).
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status	Enter the resource's current status. <ul style="list-style-type: none"> <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____ <ul style="list-style-type: none"> • Assigned – Assigned to the incident. • O/S Rest – Out-of-service for rest/recuperation purposes/guidelines, or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft. • O/S Pers – Out-of-service for personnel reasons. • Available – Available to be assigned to the incident. • O/S Mech – Out-of-service for mechanical reasons. • ETR – Estimated time of return.
Notes	Enter any additional information pertaining to the resource's current location or status.

Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).
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ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type	Name/ID #	
<i>Front</i>			
Date/Time Checked In:			
Pilot Name:			
Home Base:			
Departure Point:			
ETD:		ETA:	
Destination Point:			
Date/Time Ordered:			
Remarks:			
Prepared by:			
Date/Time:			
ICS 219-4 HELICOPTER (BLUE)			

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type	Name/ID #	
<i>Back</i>			

Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		
Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		
Incident Location:	Time:	
Status:		
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____
Notes:		
ICS 219-4 HELICOPTER (BLUE)		

ICS 219-4: Helicopter Card

Block Title	Instructions
ST/Unit	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include the pilot.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., IORC, ARL, NYPD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier.
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Pilot Name:	Enter pilot's name (Use at least the first initial and last name).
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the destination point.
Destination Point	Use this section to enter the location at the incident where the resource has been requested to report.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____	Enter the resource's current status: <ul style="list-style-type: none"> • Assigned – Assigned to the incident • O/S Rest – Out-of-service for rest/recuperation purposes/guidelines or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft • O/S Pers – Out-of-service for personnel reasons • Available – Available to be assigned to the incident • O/S Mech – Out-of-service for mechanical reasons • ETR – Estimated time of return
Notes	Enter any additional information pertaining to the resource's current location or status.
Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).

ST/Unit:	Name:	Position/Title:
Front		
Date/Time Checked In:		
Name:		
Primary Contact Information:		
<input type="checkbox"/> Manifest: <input type="checkbox"/> Total Weight:		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ME <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Method of Travel to Incident:		
ACV POV Bus Air Other		
Home Base:		
Departure Point:		
ETD: <input type="checkbox"/> ETA: <input type="checkbox"/>		
Transportation Needs at Incident:		
Vehicle Bus Air Other		
Date/Time Ordered:		
Remarks:		
Prepared by:		
Date/Time:		
ICS 219-5 PERSONNEL (WHITE CARD)		

ST/Unit:	Name:	Position/Title:
Back		
Incident Location:		Time:
Status:		
<input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR		
Notes:		
Incident Location:		Time:
Status:		
<input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR		
Notes:		
Incident Location:		Time:
Status:		
<input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR		
Notes:		
Prepared by:		
Date/Time:		
ICS 219-5 PERSONNEL (WHITE CARD)		

ICS 219-5: Personnel Card

Block Title	Instructions
ST/Unit	Enter the State and or unit identifier (3-5 letters) used by the authority having jurisdiction.
Name	Enter the individual's first initial and last name.
Position/Title	Enter the individual's ICS position/title.
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Name:	Enter the individual's full name.
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code and any satellite phone specifics.
Manifest <input type="checkbox"/> Yes <input type="checkbox"/> No	Use this section to enter whether or not the resource or personnel has a manifest. If they do, indicate the manifest number.
Total Weight:	Enter the total weight for the crew. This information is necessary when the crew are transported by charter air.
Method of Travel to Incident <input type="checkbox"/> AOV <input type="checkbox"/> POV <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other	Check the box(es) for the appropriate method(s) of travel the individual used to bring himself/herself to the incident. AOV is "agency-owned vehicle." POV is "privately owned vehicle."
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the crew's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the crew's estimated time of arrival (using the 24-hour clock) at the incident.
Transportation Needs at Incident <input type="checkbox"/> Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Air <input type="checkbox"/> Other	Check the box(es) for the appropriate method(s) of transportation at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the crew was ordered to the incident.
Remarks	Enter any additional information pertaining to the crew.
BACK OF FORM	
Incident Location	Enter the location of the crew.

Time	Enter the time (24-hour clock) the crew reported to this location.
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Block Title	Instructions
Status <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____	Enter the crew's current status. <ul style="list-style-type: none"> • Assigned – Assigned to the incident • O/S Rest – Out-of-service for rest/recuperation purposes/guidelines, or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft • O/S Pers – Out-of-service for personnel reasons • Available – Available to be assigned to the incident • O/S Mech – Out-of-service for mechanical reasons • ETR – Estimated time of return
Notes	Enter any additional information pertaining to the crew's current location or status.
Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type	Name/ID #	
<i>Front</i>			
Date/Time Checked-In:			
Pilot Name:			
Home Base:			
Departure Point:			
ETD:		ETA:	
Destination Point:			
Date/Time Ordered:			
Manufacturer:			
Remarks:			

Prepared by:
Date/Time:
ICS 219-6 FIXED-WING (ORANGE)

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #
<i>Back</i>			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Prepared by:			
Date/Time:			
ICS 219-6 FIXED-WING (ORANGE)			

ICS 219-6: Fixed-Wing Card

Block Title	Instructions
ST/Unit	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include the pilot.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYPD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier.
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Pilot Name	Enter pilot's name (use at least the first initial and last name).
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the destination point.
Destination Point	Use this section to enter the location at the incident where the resource has been requested to report.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Manufacturer	Enter the manufacturer of the aircraft.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR _____	Enter the resource's current status: <ul style="list-style-type: none"> • Assigned – Assigned to the incident • O/S Rest – Out of service for rest/recuperation purposes/guidelines, or due to operating time limits/policies for pilots, operators, drivers, equipment, or aircraft • O/S Pers – Out of service for personnel reasons • Available – Available to be assigned to the incident • O/S Mech – Out of service for mechanical reasons • ETR – Estimated time of return
Notes	Enter any additional information pertaining to the resource's current location or status.
Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).

ICS 219-7: Equipment Card

Block Title	Instructions
ST/Unit	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include leaders.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYFD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier (e.g., 13 Bluewater Utility 22).
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Leader Name	Enter resource leader's name (use at least the first initial and last name).
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code & any satellite phone specifics.
Resource ID #(s) or Name(s)	Provide the identifier number(s) or name(s) for this resource.
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status	Enter the resource's current status. <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____
Notes	Enter any additional information pertaining to the resource's current location or status.

Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).
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ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #
<i>Front</i>			
Date/Time Checked In:			
Leader Name:			
Primary Contact Information:			
Resource ID #(s) or Name(s):			
Home Base:			
Departure Point:			
ETD:		ETA:	
Date/Time Ordered:			

Remarks:
Prepared by:
Date/Time:
ICS 219-8 MISCELLANEOUS EQUIPMENT/TASK FORCE (TAN)

ST/Unit:	LDW:	# Pers:	Order#:
Agency	Cat/Kind/Type		Name/ID #
<i>Back</i>			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Prepared by:			
Date/Time:			
ICS 219-8 MISCELLANEOUS EQUIPMENT/TASK FORCE (TAN)			

ICS 219.8) Miscellaneous Equipment/Task Force Card

Block Title	Instructions
ST/Unit:	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available work day that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include leaders.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYPD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier (e.g., "13 Bluewater Utility 32").
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Leader Name	Enter resource leader's name (use at least the first initial and last name).
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code & any satellite phone specifics.
Resource ID #(s) or Name(s)	Provide the identifier number or name for this resource.
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status	Enter the resource's current status: <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____
Notes	Enter any additional information pertaining to the resource's current location or status.

Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).
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ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type		Name/ID #
<i>Front</i>			
Date/Time Checked In:			
Leader Name:			
Primary Contact Information:			
Resource ID #(s) or Name(s):			
Home Base:			
Departure Point:			
ETD:		ETA:	
Date/Time Ordered:			

Remarks:
Prepared by:
Date/Time:
ICS 219-10 GENERIC (LIGHT PURPLE)

ST/Unit:	LDW:	# Pers:	Order #:
Agency	Cat/Kind/Type	Name/ID #	
<i>Back</i>			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Incident Location:		Time:	
Status:			
<input type="checkbox"/> Assigned	<input type="checkbox"/> O/S Rest	<input type="checkbox"/> O/S Pers	
<input type="checkbox"/> Available	<input type="checkbox"/> O/S Mech	<input type="checkbox"/> ETR: _____	
Notes:			
Prepared by:			
Date/Time:			
ICS 219-10 GENERIC (LIGHT PURPLE)			

ICS 219.10: Generic Card

Block Title	Instructions
ST/Unit:	Enter the State and/or unit identifier (3-5 letters) used by the authority having jurisdiction.
LDW (Last Day Worked)	Indicate the last available workday that the resource is allowed to work.
# Pers	Enter total number of personnel associated with the resource. Include leaders.
Order #	The order request number will be assigned by the agency dispatching resources or personnel to the incident. Use existing protocol as appropriate for the jurisdiction and/or discipline since several incident numbers may be used for the same incident.
Agency	Use this section to list agency name or designator (e.g., ORC, ARL, NYFD).
Cat/Kind/Type	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance.
Name/ID #	Use this section to enter the resource name or unique identifier (e.g., 13, Bluewater Utility 32).
Date/Time Checked In	Enter date (month/day/year) and time of check-in (24-hour clock) to the incident.
Leader Name	Enter resource leader's name (use at least the first initial and last name).
Primary Contact Information	Enter the primary contact information (e.g., cell phone number, radio, etc.) for the leader. If radios are being used, enter function (command, tactical, support, etc.), frequency, system, and channel from the Incident Radio Communications Plan (ICS 205). Phone and pager numbers should include the area code & any satellite phone specifics.
Resource ID #(s) or Name(s)	Provide the identifier number(s) or name(s) for this resource.
Home Base	Enter the home base to which the resource or individual is normally assigned (may not be departure location).
Departure Point	Enter the location from which the resource or individual departed for this incident.
ETD	Use this section to enter the resource's estimated time of departure (using the 24-hour clock) from their home base.
ETA	Use this section to enter the resource's estimated time of arrival (using the 24-hour clock) at the incident.
Date/Time Ordered	Enter date (month/day/year) and time (24-hour clock) the resource was ordered to the incident.
Remarks	Enter any additional information pertaining to the resource.
BACK OF FORM	
Incident Location	Enter the location of the resource.
Time	Enter the time (24-hour clock) the resource reported to this location.
Status	Enter the resource's current status: <input type="checkbox"/> Assigned <input type="checkbox"/> O/S Rest <input type="checkbox"/> O/S Pers <input type="checkbox"/> Available <input type="checkbox"/> O/S Mech <input type="checkbox"/> ETR: _____
Notes	Enter any additional information pertaining to the resource's current location or status.

Prepared by Date/Time	Enter the name of the person preparing the form. Enter the date (month/day/year) and time prepared (using the 24-hour clock).
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AIR OPERATIONS SUMMARY (ICS 220)

1. Incident Name:		2. Operational Period: Date From: _____ Date To: _____ Time From: _____ Time To: _____			3. Sunrise: _____ Sunset: _____	
4. Remarks (safety notes, hazards, air operations special equipment, etc.):		5. Ready Alert Aircraft: Medivac: New Incident:			6. Temporary Flight Restriction Number: Altitude: Center Point:	
		8. Frequencies:		AM	FM	9. Fixed-Wing (category/kind/type, make/model, N#, base): Air Tactical Group Supervisor Aircraft:
		Air/Air Fixed-Wing				
7. Personnel:	Name:	Phone Number:	Air/Air Rotary-Wing – Flight Following			
Air Operations Branch Director			Air/Ground			
Air Support Group Supervisor			Command			Other Fixed-Wing Aircraft:
Air Tactical Group Supervisor			Deck Coordinator			
Helicopter Coordinator			Take-Off & Landing Coordinator			
Helibase Manager			Air Guard			
10. Helicopters (use additional sheets as necessary):						
FAA N#	Category/Kind/Type	Make/Model	Base	Available	Start	Remarks



11. Prepared by: Name: _____	Position/Title: _____	Signature: _____
ICS 220, Page 1	Date/Time: _____	

CONFIDENTIAL

11. Prepared by: Name: _____ Position/Title: _____ Signature: _____	
ICS 220, Page 2	Date/Time: _____

CONFIDENTIAL

ICS 220

Air Operations Summary

Purpose. The Air Operations Summary (ICS 220) provides the Air Operations Branch with the number, type, location, and specific assignments of helicopters and air resources.

Preparation. The ICS 220 is completed by the Operations Section Chief or the Air Operations Branch Director during each Planning Meeting. General air resources assignment information is obtained from the Operational Planning Worksheet (ICS 215) which also is completed during each Planning Meeting. Specific designators of the air resources assigned to the incident are provided by the Air and Fixed-Wing Support Groups. If aviation assets would be utilized for rescue or are referenced on the Medical Plan (ICS 206), coordinate with the Medical Unit Leader and indicate on the ICS 206.

Distribution. After the ICS 220 is completed by Air Operations personnel, the form is given to the Air Support Group Supervisor and Fixed-Wing Coordinator personnel. These personnel complete the form by indicating the designators of the helicopters and fixed-wing aircraft assigned missions during the specified operational period. This information is provided to Air Operations personnel who, in turn, give the information to the Resources Unit.

Notes:

- If additional pages are needed for any form page, use a blank ICS 220 and repage as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period <ul style="list-style-type: none">• Date and Time From• Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	Sunrise/Sunset	Enter the sunrise and sunset times.
4	Remarks (safety notes, hazards, air operations special equipment, etc.)	Enter special instructions or information, including safety notes, hazards, and priorities for Air Operations personnel.
5	Ready Alert Aircraft <ul style="list-style-type: none">• Medivac• New Incident	Identify ready alert aircraft that will be used as Medivac for incident assigned personnel and indicate on the Medical Plan (ICS 206). Identify aircraft to be used for new incidents within the area or new incident(s) within an incident.
6	Temporary Flight Restriction Number <ul style="list-style-type: none">• Altitude• Center Point	Enter Temporary Flight Restriction Number, altitude (from the center point), and center point (latitude and longitude). This number is provided by the Federal Aviation Administration (FAA) or is the order request number for the Temporary Flight Restriction.
7	Personnel <ul style="list-style-type: none">• Name• Phone Number	Enter the name and phone number of the individuals in Air Operations.
	Air Operations Branch Director	
	Air Support Group Supervisor	
	Air Tactical Group Supervisor	
	Helicopter Coordinator	
	Helibase Manager	

Block Number	Block Title	Instructions	
8	Frequencies	Enter primary air/air, air/ground (if applicable), command, deck coordinator, take-off and landing coordinator, and other radio frequencies to be used during the incident.	
	<ul style="list-style-type: none"> • AM • FM 		
	Air/Air Fixed-Wing		
	Air/Air Rotary-Wing - Flight Following		Flight following is typically done by Air Operations.
	Air/Ground		
	Command		
	Deck Coordinator		
9	Fixed-Wing (category/kind/type, make/model, N# base)	Enter the category/kind/type based on NIMS, discipline, or jurisdiction guidance, make/model, N#, and base of air assets allocated to the incident.	
	Air Tactical Group Supervisor Aircraft		
	Other Fixed-Wing Aircraft		
10	Helicopters	Enter the following information about the helicopter resources allocated to the incident.	
	FAA N#		Enter the FAA N#.
	Category/Kind/Type		Enter the helicopter category/kind/type based on NIMS, discipline, or jurisdiction guidance.
	Make/Model		Enter the make and model of the helicopter.
	Base		Enter the base where the helicopter is located.
	Available		Enter the time the aircraft is available.
	Start		Enter the time the aircraft becomes operational.
11	Prepared by	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).	
	<ul style="list-style-type: none"> • Name • Position/Title • Signature • Date/Time 		
12	Task/Mission/Assignment (category/kind/type and function includes: air tactical, reconnaissance, personnel transport, search and rescue, etc.)	Enter the specific assignment (e.g., water or retardant drops, logistical support, or availability status for a specific purpose, support backup, recon, Medivac, etc.). If applicable, enter the primary air/air and air/ground radio frequency to be used. Mission assignments may be listed by priority.	
	Category/Kind/Type and Function		
	Name of Personnel or Cargo (if applicable) or Instructions for Tactical Aircraft		
	Mission Start		
	Fly From		Enter the incident location or air base the aircraft is flying from.
	Fly To		Enter the incident location or air base the aircraft is flying to.

DEMOBILIZATION CHECK-OUT (ICS 221)

1. Incident Name:		2. Incident Number:	
3. Planned Release Date/Time: Date _____ Time _____		4. Resource or Personnel Released:	5. Order Request Number:
6. Resource or Personnel: You and your resources are in the process of being released. Resources are not released until the checked boxes below have been signed off by the appropriate overhead and the Demobilization Unit Leader (or Planning Section representative)			
LOGISTICS SECTION			
<input type="checkbox"/>	Unit/Manager	Remarks	Name Signature
<input type="checkbox"/>	Supply Unit		
<input type="checkbox"/>	Communications		
<input type="checkbox"/>	Unit Facilities Unit		
<input type="checkbox"/>	Ground Support		
<input type="checkbox"/>	Unit Security		
<input type="checkbox"/>	Manager		
FINANCE/ADMINISTRATION SECTION			
<input type="checkbox"/>	Unit/Leader	Remarks	Name Signature
<input type="checkbox"/>	Time Unit		
<input type="checkbox"/>	Unit/Other	Remarks	Name Signature
<input type="checkbox"/>			
OTHER SECTION/STAFF			
<input type="checkbox"/>	Unit/Leader	Remarks	Name Signature
<input type="checkbox"/>			
PLANNING SECTION			
<input type="checkbox"/>	Demobilization Leader		
<input type="checkbox"/>	Demobilization Leader		
7. Remarks:			
<input type="checkbox"/> <input type="checkbox"/>			
8. Travel Information:			
Room Overnight: Yes No		Date/Time:	
Estimated Time of Departure: _____		Actual Release _____	
Destination: _____		Estimated Time of Arrival _____	
Travel Method: _____		Contact Information While Travelling _____	
Manifest: Yes No		Area/Agency/Region Notified _____	
Number: _____			

9. Reassignment Information: Yes No	
Incident Name: _____	Incident Number: _____
_____	Location: _____
_____	Order Request Number: _____
10. Prepared by: Name: _____ Position/Title: _____ Signature: _____	
ICS 221	Date/Time: _____

ICS 221

Demobilization Check-Out

Purpose. The Demobilization Check-Out (ICS 221) ensures that resources checking out of the incident have completed all appropriate incident business, and provides the Planning Section information on resources released from the incident. Demobilization is a planned process and this form assists with that planning.

Preparation. The ICS 221 is initiated by the Planning Section, or a Demobilization Unit Leader if designated. The Demobilization Unit Leader completes the top portion of the form and checks the appropriate boxes in Block 6 that may need attention after the Resources Unit Leader has given written notification that the resource is no longer needed. The individual resource will have the appropriate overhead personnel sign off on any checked box(es) in Block 6 prior to release from the incident.

Distribution. After completion, the ICS 221 is returned to the Demobilization Unit Leader or the Planning Section. All completed original forms must be given to the Documentation Unit. Personnel may request to retain a copy of the ICS 221.

Notes:

- Members are not released until form is complete when all of the items checked in Block 6 have been signed off.
- If additional pages are needed for any form page, use a blank ICS 221 and repaginate as needed.

Block Number	Block Title	Instructions
1	Incident Name	Enter the name assigned to the incident.
2	Incident Number	Enter the number assigned to the incident.
3	Planned Release Date/Time	Enter the date (month/day/year) and time (using the 24-hour clock) of the planned release from the incident.
4	Resource or Personnel Released	Enter name of the individual or resource being released.
5	Order Request Number	Enter order request number (or agency demobilization number) of the individual or resource being released.
6	Resource or Personnel You and your resources are in the process of being released. Resources are not released until the checked boxes below have been signed off by the appropriate overhead and the Demobilization Unit Leader (or Planning Section representative). • Unit/Leader/Manager/Other: • Remarks • Name • Signature	Resources are not released until the checked boxes below have been signed off by the appropriate overhead. Blank boxes are provided for any additional unit requirements as needed (e.g. Safety Officer, Agency Representative, etc.)
	Logistics Section <input type="checkbox"/> Supply Unit <input type="checkbox"/> Communications Unit <input type="checkbox"/> Facilities Unit <input type="checkbox"/> Ground Support Unit <input type="checkbox"/> Security Manager	The Demobilization Unit Leader will enter an "X" in the box to the left of those Units requiring the resource to check out. Identified Unit Leaders or other overhead are to sign the appropriate line to indicate release.

Block Number	Block Title	Instructions
6 (continued)	Finance/Administration Section <input type="checkbox"/> Time Unit	The Demobilization Unit Leader will enter an "X" in the box to the left of those Units requiring the resource to check out. Identified Unit Leaders or other overhead are to sign the appropriate line to indicate release.
	Other Section/Staff <input type="checkbox"/>	The Demobilization Unit Leader will enter an "X" in the box to the left of those Units requiring the resource to check out. Identified Unit Leaders or other overhead are to sign the appropriate line to indicate release.
	Planning Section <input type="checkbox"/> Documentation Leader <input type="checkbox"/> Demobilization Leader	The Demobilization Unit Leader will enter an "X" in the box to the left of those Units requiring the resource to check out. Identified Unit Leaders or other overhead are to sign the appropriate line to indicate release.
7	Remarks	Enter any additional information pertaining to demobilization or release (e.g., transportation needed, destination, etc.). This section may also be used to indicate if a performance rating has been completed as required by the discipline or jurisdiction.
8	Travel Information	Enter the following travel information:
	Room Overnight	Use this section to enter whether or not the resource or personnel will be staying in a hotel overnight prior to returning home base and/or Unit.
	Estimated Time of Departure	Use this section to enter the resource's or personnel's estimated time of departure (using the 24-hour clock).
	Actual Release Date/Time	Use this section to enter the resource's or personnel's actual release date (month/day/year) and time (using the 24-hour clock).
	Destination	Use this section to enter the resource's or personnel's destination.
	Estimated Time of Arrival	Use this section to enter the resource's or personnel's estimated time of arrival (using the 24-hour clock) at the destination.
	Travel Method	Use this section to enter the resource's or personnel's travel method (e.g., PDV, air, etc.).
	Contact Information While Traveling	Use this section to enter the resource's or personnel's contact information while traveling (e.g., cell phone, radio frequency, etc.).
	Manifest <input type="checkbox"/> Yes <input type="checkbox"/> No Number	Use this section to enter whether or not the resource or personnel has a manifest. If they do, indicate the manifest number.
Area/Agency/Region Notified	Use this section to enter the area, agency, and/or region that was notified of the resource's travel. List the name (first initial and last name) of the individual notified and the date (month/day/year) he or she was notified.	
9	Reassignment Information <input type="checkbox"/> Yes <input type="checkbox"/> No	Enter whether or not the resource or personnel was reassigned to another incident. If the resource or personnel was reassigned, complete the section below.
	Incident Name	Use this section to enter the name of the new incident to which the resource was reassigned.
	Incident Number	Use this section to enter the number of the new incident to which the resource was reassigned.
	Location	Use this section to enter the location (city and State) of the new incident to which the resource was reassigned.
	Order Request Number	Use this section to enter the new order request number assigned to the resource or personnel.

Block Number	Block Title	Instructions
10	Prepared by <ul style="list-style-type: none">• Name• Position/Title• Signature• Date/Time	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (using the 24-hour clock).

INCIDENT PERSONNEL PERFORMANCE RATING (ICS 225)

THIS RATING IS TO BE USED <u>ONLY</u> FOR DETERMINING AN INDIVIDUAL'S PERFORMANCE ON AN INCIDENT/EVENT						
1. Name:		2. Incident Name:		3. Incident Number:		
4. Home Unit Name and Address:			5. Incident Agency and Address:			
6. Position Held on Incident:		7. Date(s) of Assignment: From: _____ To: _____		8. Incident Complexity Level: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
9. Incident Definition:						
10. Evaluation						
Rating Factors	N/A	1 – Unacceptable	2	3 – Met Standards	4	5 – Exceeded Expectations
<p>11. Knowledge of the Job/ Professional Competence: Ability to acquire, apply, and share technical and administrative knowledge and skills associated with description of duties. (Includes operational aspects such as engine safety, membership, membership, EAP, etc., as appropriate.)</p>	<input type="checkbox"/>	<p>Questionable competence and credibility. Operational or specialty expertise inadequate or lacking in key areas. Made little effort to grow professionally. Used knowledge as power against others or bluff, rather than acknowledging ignorance. Effectiveness reduced due to limited knowledge of own organizational role and customer needs.</p>	<input type="checkbox"/>	<p>Competent and credible authority on specialty or operational issues. Acquired and applied excellent operational or specialty expertise for essential duties. Showed professional growth through education, training, and professional reading. Shared knowledge and information with others clearly and simply. Understand own organizational role and customer needs.</p>	<input type="checkbox"/>	<p>Superior expertise; advice and actions showed great insight and depth of knowledge. Remarkable grasp of complex issues, concepts, and situations. Rapidly developed professional growth beyond expectations. Vigorously conveyed knowledge, directly resulting in increased workplace productivity. Insightful knowledge of own role, customer needs, and value of work.</p>
<p>12. Ability To Obtain Performance/Results: Quality, quantity, timeliness, and impact of work</p>	<input type="checkbox"/>	<p>Routine tasks accomplished with difficulty. Results often late or of poor quality. Work had a negative impact on department or unit. Maintained the status quo despite opportunities to improve.</p>	<input type="checkbox"/>	<p>Set the job done in all routine situations and in many unusual ones. Work was timely and of high quality; received some of subordinates. Results had a positive impact on the unit. Continuously improved services and organizational effectiveness.</p>	<input type="checkbox"/>	<p>Maintained optimal balance among quality, quantity, and timeliness of work. Quality of work and subordinates early surpassed expectations. Results had a significant positive impact on the unit. Established clearly effective systems of continuous improvement.</p>
<p>13. Planning/ Preparedness: Ability to anticipate, determine goals, identify relevant information, set priorities and deadlines, and create a unified vision of the Incident Management Team (IMT).</p>	<input type="checkbox"/>	<p>Set caught by the unexpected, appeared to be controlled by events. Set vague or unrealistic goals. Used unreasonable criteria to set priorities and deadlines. Failed to have a plan of action. Failed to have an relevant information.</p>	<input type="checkbox"/>	<p>Consistently prepared. Set high but realistic goals. Used sound criteria to set priorities and deadlines. Used quality tools and processes to develop action plans. Identified key information kept supervisors and stakeholders informed.</p>	<input type="checkbox"/>	<p>Exceptional preparation. Always looked beyond immediate events or problems. Skillfully balanced competing demands. Developed strategies with contingency plans. Assessed all aspects of problems including underlying risks and impact.</p>
<p>14. Using Resources: Ability to manage time, materials, information, money, and people (i.e., all IMT components) as well as external partners.</p>	<input type="checkbox"/>	<p>Concentrated on unproductive activities or often overlooked critical demands. Failed to use people productively. Did not follow-up. Mismanaged information, money, or time. Used ineffective tools or let subordinates waste means to accomplish tasks. Employed wasteful methods.</p>	<input type="checkbox"/>	<p>Effectively managed a variety of activities with available resources. Delegated, empowered, and followed up. Skilled time manager. Budgeted own and subordinates' time productively. Ensured subordinates had adequate tools, materials, time, and direction. Got creative, sought ways to cut waste.</p>	<input type="checkbox"/>	<p>Unusually skilled at bringing scarce resources to bear on the most critical competing demands. Optimized productivity through effective delegation, empowerment, and follow-up control. Found ways to systematically reduce and eliminate waste and improve efficiency.</p>
<p>15. Adaptability/Attitude: Ability to maintain a positive attitude and modify work methods and attitudes in response to new information, changing conditions, political realities, or unexpected obstacles.</p>	<input type="checkbox"/>	<p>Unable to gauge effectiveness of work; recognize political realities; or make adjustments when needed. Maintained a poor attitude. Overlooked or stifled out new information. Inflexible in ambiguous, complex, or pressured situations.</p>	<input type="checkbox"/>	<p>Responsive to change, new information, and technology. Effectively used benchmarks to improve performance and service. Monitored progress and changed course as required. Maintained a positive approach. Effectively dealt with pressure and ambiguity. Facilitated smooth transitions. Adjusted direction to accommodate political realities.</p>	<input type="checkbox"/>	<p>Rapidly assessed and confidently adjusted to changing conditions, political realities, new information, and technology. Very skilled at using and responding to measurement indicators. Championed organizational improvements. Effectively dealt with extremely complex situations. Turned pressure and ambiguity into constructive forces for change.</p>

<p>16. Communication Skills: Ability to speak effectively and listen to understand. Ability to express facts and ideas clearly and convincingly.</p>	<p>Unable to effectively articulate ideas and facts. Lacked preparation, confidence, or logic. Used inappropriate language or rambled. Nervous or distracting mannerisms detracted from message. Failed to listen carefully or was too argumentative. Written material frequently unclear, verbose, or poorly organized. Seldom proofread.</p>	<p>Effectively expressed ideas and facts in individual and group situations; nonverbal actions consistent with spoken message. Communicated to people at all levels to ensure understanding. Listened carefully for intended message as well as spoken words. Written material clear, concise, and logically organized. Proofread conscientiously.</p>	<p>Clearly articulated and promoted ideas before a wide range of audiences; accomplished speaker in both formal and extemporaneous situations. Adept at presenting complex or sensitive issues. Active listener: remarkable ability to listen with open mind and identify key issues. Clearly and persuasively expressed complex or controversial material, directly contributing to stated objectives.</p>
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INCIDENT PERSONNEL PERFORMANCE RATING (ICS 225)

1. Name	2. Incident Name		3. Incident Number
10. Evaluation			
Rating Factors	NA	1 - Unacceptable	2 - Meets Standards
3 - Excessive Expectations			
<p>17. Ability To Work on a Team</p> <p>Ability to manage and lead participants, teams, encourage cooperation, and deliver excellent work.</p>	<input type="checkbox"/>	<p>Used teams effectively producing results. Conflicts managed or often left unresolved. Meetings decreased team productivity. Excluded team members from vital information. Did not group effectively. Did not collaborate productively. Did not take functional responsibility to the detriment of unit or service goals.</p>	<p>Skilledly used teams to increase unit effectiveness, quality, and service. Resolved or managed group conflict, increased cooperation, and involved team members in decision process. Maximized team participation. Effectively motivated work across functional boundaries to ensure support of functional unit goals.</p>
<p>18. Consideration for Personnel Team Welfare</p> <p>Ability to consider and respond to others, personal needs, capabilities, and environment, support and application of variable strategies, and skills.</p>	<input type="checkbox"/>	<p>Seldom recognized or responded to needs of people left outside response area. Ignored or minimized capabilities of individual personnel. Provided minimal recognition/minimal learning opportunities to other ICI members.</p>	<p>Cared to people. Recognized and responded to their needs related to safety concerns. As appropriate considered individual capabilities to maximize opportunities for success. Consistently recognized and rewarded deserving subordinates or other ICI members.</p>
<p>19. Directing Others</p> <p>Ability to influence or direct others in accomplishing tasks or missions.</p>	<input type="checkbox"/>	<p>Struggled difficult in directing or influencing others. Low or no team work or group cohesion. Productivity rates to hold responsibilities unacceptable for specific work or to responsible for this difficulty to decrease efficiency of task accomplishment.</p>	<p>A leader who earned others' support and commitment. Set high work standards. Clearly articulated job assignments, expectations, and requirements. Motivated subordinates. Delegated authority to those directly responsible for the task.</p>
<p>20. Judgment/Decision Under Stress</p> <p>Ability to make sound decisions and provide recommendations by using facts, experience, public opinion, common sense, gut instinct, and analytical thought.</p>	<input type="checkbox"/>	<p>Committed after deployed past analysis. Failed to make reasonable decisions or jumped to conclusions without considering facts, alternatives, and impact. Did not effectively weigh the risk and time considerations. () Worked with positive errors of a conclusion.</p>	<p>Demonstrated analytical thought and common sense in making decisions. Used facts, data, and experience and considered the impact of alternatives and actual realities. Weighed the cost and time considerations. Made sound decisions. () Worked with the best available information.</p>
<p>21. Initiative</p> <p>Ability to originate and act on new ideas, give suggestions to team and supervisor, and seek responsibility without guidance and supervision.</p>	<input type="checkbox"/>	<p>Responded to ideas and implemented or supported improvements only when directed to do so. Showed little interest in basic development. Minimal improvements without supervisor approval/feedback.</p>	<p>Championed improvement through new ideas, methods, and practices. Anticipated problems and took prompt action to avoid or reduce them. Pursued production goals and improved mission performance by applying new ideas and methods.</p>
<p>22. Physical Ability for the Job</p> <p>Ability to meet or be (MT) able by using the physical health and personal well-being of self and others.</p>	<input type="checkbox"/>	<p>Fitness level minimum standard of ability. Tolerated or condoned dangerous conditions. Ignored or considered substandard health and well-being of himself or unable to recognize and () the signs, despite approval/need.</p>	<p>Committed to health and well-being of self and subordinates. Encouraged personal performance through activities supporting physical and emotional well-being. Recognized and motivated others accordingly.</p>
<p>23. Adherence to Safety</p> <p>Ability to report to the ICI a failure to comply to the safety of self and others.</p>	<input type="checkbox"/>	<p>Ignored safety violations and related personnel safety hazards.</p>	<p>Ensured the safety related procedures were followed. ()</p>
24. Remarks:			
25. Rated Individual (if this rating has been discussed with them):			
Signature _____		Date/Time _____	

26. Rated by: Name: _____		Signature: _____	
Home Unit: _____		Position Held on This Incident: _____	
ICS 225	Date/Time: _____		

**ICS 225
Incident Personnel Performance Rating**

Purpose. The Incident Personnel Performance Rating (ICS 225) gives supervisors the opportunity to evaluate subordinates on incident assignments. THIS RATING IS TO BE USED ONLY FOR DETERMINING AN INDIVIDUAL'S PERFORMANCE ON AN INCIDENT/EVENT.

Preparation. The ICS 225 is normally prepared by the supervisor for each subordinate, using the evaluation standard given in the form. The ICS 225 will be reviewed with the subordinate, who will sign at the bottom. It will be delivered to the Planning Section before the rater leaves the incident.

Distribution. The ICS 225 is provided to the Planning Section Chief before the rater leaves the incident.

Notes:

- Use a blank ICS 225 for each individual.
- Additional pages can be added based on individual need.

Block Number	Block Title	Instructions
1	Name	Enter the name of the individual being rated.
2	Incident Name	Enter the name assigned to the incident.
3	Incident Number	Enter the number assigned to the incident.
4	Home Unit Address	Enter the physical address of the home unit for the individual being rated.
5	Incident Agency and Address	Enter the name and address of the authority having jurisdiction for the incident.
6	Position Held on Incident	Enter the position held (e.g., Resources Unit Leader, Safety Officer, etc.) by the individual being rated.
7	Date(s) of Assignment • From: • To:	Enter the date(s) (month/day/year) the individual was assigned to the incident.
8	Incident Complexity Level <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Indicate the level of complexity for the incident.
9	Incident Definition	Enter a general definition of the incident in this block. This may be a general incident category or kind description, such as "tornado," "wildfire," "bridge collapse," "civil unrest," "parade," "vehicle fire," "mass casualty," etc.
10	Evaluation	Enter "X" under the appropriate column indicating the individual's level of performance for each duty listed.
	N/A	The duty did not apply to this incident.
	1 – Unacceptable	Does not meet minimum requirements of the individual element. Deficiencies/Improvements needed must be identified in Remarks.
	2 – Needs Improvement	Meets some or most of the requirements of the individual element. IDENTIFY IMPROVEMENT NEEDED IN REMARKS.
	3 – Met Standards	Satisfactory. Employee meets all requirements of the individual element.

Block Number	Block Title	Instructions
	4 – Fully Successful	Employee meets all requirements and exceeds one or several of the requirements of the individual element.
10	5 – Exceeded Expectations	Superior: Employee consistently exceeds the performance requirements.
11	Knowledge of the Job/ Professional Competence:	Ability to acquire, apply, and share technical and administrative knowledge and skills associated with description of duties. (Includes operational aspects such as marine safety, seamanship, airmanship, SAR, etc., as appropriate.)
12	Ability To Obtain Performance/Results:	Quality, quantity, timeliness, and impact of work.
13	Planning/Preparedness:	Ability to anticipate, determine goals, identify relevant information, set priorities and deadlines, and create a shared vision of the Incident Management Team (IMT).
14	Using Resources:	Ability to manage time, materials, information, money, and people (i.e., all IMT components as well as external publics).
15	Adaptability/Attitude:	Ability to maintain a positive attitude and modify work methods and priorities in response to new information, changing conditions, political realities, or unexpected obstacles.
16	Communication Skills:	Ability to speak effectively and listen to understand. Ability to express facts and ideas clearly and convincingly.
17	Ability To Work on a Team:	Ability to manage, lead and participate in teams; encourage cooperation, and develop esprit de corps.
18	Consideration for Personnel/Team Welfare:	Ability to consider and respond to others' personal needs, capabilities, and achievements; support for and application of worklife concepts and skills.
19	Directing Others:	Ability to influence or direct others in accomplishing tasks or missions.
20	Judgment/Decisions Under Stress:	Ability to make sound decisions and provide valid recommendations by using facts, experience, political acumen, common sense, risk assessment, and analytical thought.
21	Initiative	Ability to originate and act on new ideas, pursue opportunities to learn and develop, and seek responsibility without guidance and supervision.
22	Physical Ability for the Job:	Ability to invest in the IMT's future by caring for the physical health and emotional well-being of self and others.
23	Adherence to Safety:	Ability to invest in the IMT's future by caring for the safety of self and others.
24	Remarks	Enter specific information on why the individual received performance levels.
25	Rated Individual (This rating has been discussed with me) • Signature • Date/Time	Enter the signature of the individual being rated. Enter the date (month/day/year) and the time (24-hour clock) signed.
26	Rated by • Name • Signature • Home Unit • Position Held on This Incident • Date/Time	Enter the name, signature, home unit, and position held on the incident of the person preparing the form and rating the individual. Enter the date (month/day/year) and the time (24-hour clock) prepared.

1. Incident Name		2. Operational Period (Date/Time) From: _____ To: _____		DAILY MEETING SCHEDULE ICS 230-CG	
3. Meeting Schedule (Commonly-held meetings are included)					
Date/ Time	Meeting Name	Purpose	Attendees	Location	
	Unified Command Objectives Meeting	Review/identify objectives for the next operational period.	Unified Command members	UC Meeting Room	
	Command and General Staff meeting	UC Presents direction to Command and General Staff	UC, Command Staff, General Staff, DOCL, SITL	ICP Meeting Room	
	Tactics Meeting	Develop primary and alternate strategies/to meet Incident Objectives for the next Operational Period.	PSC, OPS, LSC, RESL, SITL, SOFR, DOCL, COML, THSP	ICP Meeting Room	
	Planning Meeting	Review status and finalize strategies/tactics and assignments to meet Incident Objectives for the next Operational Period and get tacit approval of IAP.	UC, Command Staff, General Staff, SITL, DOCL, THSP	ICP Meeting Room	
	Operations Briefing	Present IAP and assignments to the Supervisors / Leaders for the next Operational Period.	IC/UC, Command Staff, General Staff, Branch Directors, Div./Grp Sups., Task Force/ Strike Team Leaders and Unit Leaders	ICP Meeting Room	
4. Prepared by: (Situation Unit Leader)			Date/Time		
DAILY MEETING SCHEDULE				ICS 230-CG(Rev.09/05)	

1. Incident Name:		INCIDENT OPEN ACTION TRACKER					
		ICS-233 CG					
2. No.	3. Item	4. For/POC	5. Briefed POC (X)	6. Start Date	7. Status	8. Target Date	9. Actual Date
1							
2							
3							
4							
5							
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CONFIDENTIAL

Purpose. Open Actions Tracker

1. Is used by the Incident Commander/Unified Command (IC/UC) to assign and track tasks/actions to IMT personnel that do not rise to the level of being an Incident Objective.

2. Is duplicated and provided to Command and General Staff members, giving them the open tasks/actions needing to be completed and a means to track the open tasks/actions they have been assigned.

Note: This form may also be used by Command and General Staff for tracking tasks/actions within a Section/Staff element.

Preparation. The Planning Section Chief (PSC) is responsible for maintaining the Open Actions Tracker for the IC/UC and typically utilizes the Documentation Unit Leader (DOCL) to assist in this forms development and updating. The PSC should ensure all Command and General Staff are prepared to discuss their assigned tasks/actions during the Command and General Staff and Planning Meetings.

Distribution. When completed, the form is duplicated and copies are distributed to the Unified Command and Command and General Staff. It is also posted on a status board located at the ICP. All completed original forms MUST be given to the Documentation Unit.

<u>Item #</u>	<u>Item Title</u>	<u>Instructions</u>
1.	Incident Name	Enter the name assigned to the incident.
2.	No.	Enter number of task in sequential order (1, 2, 3, ...)
3.	Item	Enter short descriptive of the task/action to be completed. Tasks/Actions are important to be completed but are not an Incident Objective which are documented on the ICS-202 form.
4.	For/POC	Enter the Point of Contact (POC), the responsible person/section.
5.	Briefed to POC	Enter "X", when the task/action has been briefed to the POC/responsible person. This is to ensure that tasks/actions identified outside of the POC's presence (during Unified Command Meeting for example) are briefed to and acknowledged by the identified POC.
6.	Start Date	Enter the date the task/action was initially assigned under "Start Date."
7.	Status	Enter status of item. For example: "Awaiting LE Gear", "Update needed", "Awaiting Feedback". When the item is completed, the word "completed" is entered and if working in MS Excel, the task is cut and pasted into the worksheet labeled "COMPLETED."
8.	Target Date	Enter deadline task/action should be completed. In the Excel Worksheet, there is a hidden formula that shows green, yellow and red blocks. When the target date is one day away, the block turns yellow. When it is overdue it turns red. When the block is yellow, it serves as a reminder to the UC/POC that the target date is nearing and the POC needs to complete the task or the target date needs to be updated.
9.	Actual Date	Enter actual date task/action completed.

NOTE: In order to ensure the red and yellow reminders work for new tasks, the user simply copies a task line, inserts it into the worksheet and overtypes the new task information.

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2. Letter From Chief Financial Officer



Johnson County RFP
Financial Information
May 2024

For 45 years, CareFlite has protected North Texas. The oldest joint use air medical program in the United States, CareFlite has transported over 1.3 million patients since its founding in 1979. CareFlite is partnered with Texas Health Resources (50% owner), Baylor Scott and White (25%), Methodist Health Systems (25%), and non-voting members DPS Health Network and Parkland Hospital System.

CareFlite has operated financially independent from the member hospital systems for the last 20+ years with incredible growth and results over that time. Per CareFlite's agreement with its member systems, any support for capital assets can be brought to the members and the purchase of the assets will be made by the members for CareFlite. CareFlite has positioned itself to not need such requests and has plenty of capital in investments and accounts to handle the expansion into Johnson County, regardless of the financial backings by 5 major hospital systems.

Information provided in the audited financial statements will include: the Statements of Financial Position (balance sheet), Statements of operations and changes in net assets (income statement), and Statements of cash flows. A statement of owners' equities is not applicable to CareFlite's operations as a 501(c)(3) charitable organization. The financials will also include the audit opinion and a list of debt obligations related to the financings of our air fleet.

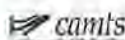
Regarding billing CareFlite has a great history in billing Medicare and Medicaid and is current in all contractual obligations with those payors. CareFlite is currently in contract with Scott and White Healthplan, Aetna, and United Healthcare insurance. Cigna and Blue Cross Blue Shield are in negotiations to gain an in-network status. The No Surprise Billing Act has impacted our financials the last year and a half negatively. This has allowed our out of network payors (BCBS primarily) to pay far less for the services than in the past. CareFlite has now started taking all air trips from these payors to the independent dispute resolution (IDR) portals, and so far is 100% in determinations from the process. This will have a positive affect on CareFlite's financials and be a strong negotiating tool for getting in network with the other 2 major insurance companies. CareFlite's other major payors are private pay patients, which has a low collection percentage and billings back to our member hospitals. Member billings (sponsor billings) are always paid in full and on time.

If there are any further questions, please reach out.

Thank you,

Dustin Kahler
VP/CFO

3110 S. Great Southwest Parkway • Grand Prairie, Texas 75052
(972) 339-4200 Business Office



3. Financial Statements and Report of Independent Certified Public Accounts 2022

Financial Statements and Report of
Independent Certified Public
Accountants

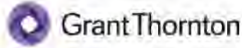
CareFlite

September 30, 2022 and 2021



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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors
CareFlite

Opinion

We have audited the financial statements of CareFlite (the "Company"), which comprise the balance sheets as of September 30, 2022 and 2021, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company as of September 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for opinion

We conducted our audits of the financial statements in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of management for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable

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assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Grant Thornton LLP

Dallas, Texas
December 7, 2022

CareFlite
STATEMENTS OF FINANCIAL POSITION
September 30,

	2022	2021
ASSETS		
Current assets		
Cash and cash equivalents	\$ 21,080,462	\$ 42,557,762
Investments	15,685,330	-
Restricted cash	-	33,059
Patient accounts receivable, net of allowance for doubtful accounts of \$42,017,513 and \$35,595,280	20,025,316	21,095,111
Accounts receivable - non-patient	266,027	205,350
Inventories	623,624	629,224
Prepaid expenses and deposits	1,491,256	1,361,740
Total current assets	59,172,015	65,882,246
Property and equipment, net	35,567,041	34,628,133
Total assets	\$ 94,739,056	\$ 100,510,379
LIABILITIES AND NET ASSETS		
Current liabilities		
Current maturities of long-term debt, net	\$ 2,371,458	\$ 2,649,621
Accounts payable	1,585,353	2,316,404
Current deferred revenue	412,241	1,192,340
Accrued liabilities	5,562,286	5,800,231
Estimated settlement due to third-party payors	-	1,473,678
Total current liabilities	9,931,338	13,432,274
Long-term liabilities		
Long-term debt, net	16,959,130	19,293,528
Long-term deferred revenue	653,946	682,798
Total long-term liabilities	17,613,076	19,976,326
Total liabilities	27,544,414	33,408,600
Commitments and contingencies		
Net assets		
Net assets without donor restrictions	67,194,642	67,068,720
Net assets with donor restrictions	-	33,059
Total net assets	67,194,642	67,101,779
Total liabilities and net assets	\$ 94,739,056	\$ 100,510,379

The accompanying notes are an integral part of these financial statements.

CareFlite

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

For the years ended September 30,

	2022	2021
Revenue and other support		
Net patient service revenue, net of provision for bad debt and recoveries	\$ 78,846,452	\$ 81,254,945
Other revenue	4,589,501	4,377,364
Net assets released from restriction	33,059	12,032
Total unrestricted revenue and other support	83,469,012	85,644,341
Expenses		
Programs:		
Fixed wing	1,489,515	2,078,759
Helicopter operations	21,788,931	19,414,273
Ground operations	42,076,499	40,632,592
Supporting services:		
Operations center	3,562,881	3,368,020
General and administrative	9,644,704	8,747,272
Total expenses	78,562,530	74,240,916
Income from operations	4,906,482	11,403,425
Nonoperating income (expense)		
Contributions and grants	36,054	21,943,581
Interest expense, net	(526,433)	(662,160)
Unrealized net loss on investments	(4,314,865)	-
Net gain on disposal of property and equipment	24,684	29,859
Total nonoperating income (expense)	(4,780,560)	21,311,280
Change in net assets without donor restrictions	125,922	32,714,705
Changes in net assets with donor restrictions		
Net assets released from restriction	(33,059)	(12,032)
Change in net assets with donor restrictions	(33,059)	(12,032)
CHANGE IN NET ASSETS	92,863	32,702,673
Net assets, at beginning of year	67,101,779	34,399,106
Net assets, at end of year	\$ 67,194,642	\$ 67,101,779

The accompanying notes are an integral part of these financial statements.

CareFlite
STATEMENTS OF CASH FLOWS
For the years ended September 30,

	<u>2022</u>	<u>2021</u>
Cash flows from operating activities:		
Change in net assets	\$ 92,863	\$ 32,702,673
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	3,547,877	-3,499,415
Amortization of debt issuance costs	32,380	12,539
Provision for bad debts	55,351,955	47,626,242
Net gain on disposal of property and equipment	(24,684)	(29,859)
Unrealized loss on Investments	4,314,670	-
Change in assets and liabilities:		
Patient accounts receivable	(54,282,160)	(53,126,519)
Accounts receivable - non-patient	(60,677)	138,599
Inventories	5,600	(129,228)
Prepaid expenses and deposits	(129,516)	(888,566)
Accounts payable	(731,051)	735,200
Deferred revenue	(808,951)	58,405
Accrued liabilities	(1,711,623)	(1,733,003)
Net cash provided by operating activities	<u>5,596,683</u>	<u>28,865,898</u>
Cash flows from investing activities:		
Purchase of property and equipment	(4,486,785)	(3,483,207)
Proceeds from disposal of property and equipment	24,684	29,859
Purchase of Investments	(20,000,000)	-
Net cash used in investing activities	<u>(24,462,101)</u>	<u>(3,453,348)</u>
Cash flows from financing activities:		
Payments on long-term debt	(2,644,941)	(3,481,411)
Net cash used in financing activities	<u>(2,644,941)</u>	<u>(3,481,411)</u>
Net (decrease) increase in cash, cash equivalents, and restricted cash	(21,510,359)	21,931,139
Cash, cash equivalents, and restricted cash at beginning of year	<u>42,590,821</u>	<u>20,659,682</u>
Cash, cash equivalents, and restricted cash at end of year	<u>\$ 21,080,462</u>	<u>\$ 42,590,821</u>
Supplemental disclosures of cash flow information:		
Interest paid	<u>\$ 581,248</u>	<u>\$ 701,525</u>

The accompanying notes are an integral part of these financial statements.

CareFlite

NOTES TO FINANCIAL STATEMENTS

September 30, 2022 and 2021

NOTE A - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CareFlite (the "Company"), a 501(c)(3) tax-exempt corporation, operates a helicopter, fixed wing, and ground ambulance service in Dallas and Fort Worth, Texas, and the surrounding communities. Texas Health Resources ("THR"), Baylor University Medical Center ("BUMC") and Methodist Hospitals of Dallas ("MHD"), (collectively, the "Members") have member interests of 50%, 25% and 25%, respectively, in the Company. Dallas County Hospital District d/b/a Parkland Health and Hospital System ("DCHD") and John Peter Smith Hospital ("JPSH") are special affiliates with no membership interest.

The Board of Directors (the "Board") consists of twelve voting members. The President of the Company and the Medical Director are nonvoting members of the Board. THR has four voting members, BUMC has two voting members, MHD has two voting members, DCHD has two voting members, and JPSH has two voting members.

Basis of Presentation

The accompanying financial statements were prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP").

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Company and changes therein are classified as follows:

Net Assets Without Donor Restrictions - Net assets that are not subject to donor-imposed stipulations. Unrestricted net assets may be designated for specific purposes by action of the Board.

Net Assets with Donor Restrictions - Net assets subject to donor-imposed stipulations that may or will be met by the occurrence of a specific event or the passage of time. When a donor restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions. Contributions with donor-imposed restrictions whose restrictions are satisfied in the same period are reported as released from restrictions in that period.

Cash and Cash Equivalents

The Company considers all highly liquid investments with a maturity of 90 days or less at the time of purchase to be cash equivalents. Cash and cash equivalents include cash held in banks and money market accounts. Cash equivalents are carried at cost, which approximates fair value due to their short-term nature. The Company's cash and cash equivalents are placed with high-credit-quality financial institutions, and at times may exceed insured limits. The Company has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk.

Restricted Cash

The Company maintains a separate account for all funds received as restricted contributions from donors, unrestricted Board designated amounts, and amounts required to be held separately.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

The following table provides a reconciliation of cash, cash equivalents, and restricted cash reported within the statement of financial position that sum to the total of the same such amounts shown in the statement of cash flows.

	2022	2021
Cash and cash equivalents	\$ 21,080,462	\$ 42,557,762
Restricted cash	-	33,059
Total cash, cash equivalents, and restricted cash shown in the statement of cash flows	<u>\$ 21,080,462</u>	<u>\$ 42,590,821</u>

Accounts Receivable

Accounts receivable is recorded net of an allowance for doubtful accounts and contractual adjustments (which represent the difference between list charges and the amount received or receivable from third-party payors). The allowance for doubtful accounts is provided based on management's judgment, including such factors as payor type and prior collection history. Accounts are deemed by management to be uncollectible after 150 days and are written off at that time. Payments subsequently received on such receivables are credited to the allowance for doubtful accounts.

January 1, 2022 the No Surprise Billing Act went into effect. The act bans balanced billings from out of network air providers to patients who have certain insurances. It also requires the insurance companies and providers, who are not in network with one another, to negotiate a payment amount. If during this negotiation period no amount is agreed upon, the provider may initiate the Federal Independent Dispute Resolution (IDR) process, in which an arbitrator will rule on the amount to be paid. The law has slowed down the collections process on air trips resulting in a large increase in both accounts receivable and allowance for doubtful accounts, as the Company has many trips currently in the negotiation stages. The Company reserves the accounts receivable based on the current policies in place.

Inventories

Inventories consist of rotatable aircraft and helicopter parts, expendable parts and supplies used in treating patients. The inventory and aircraft supplies are carried at the lower of cost using the first-in, first-out method or net realizable value.

Investments

All investments are carried at fair value. Fair values of investments in a balanced pool fund that have limited marketability are based on net asset value ("NAV") as a practical expedient in estimating fair value. The NAVs are determined by the fund manager or general partner based on their best estimates using fair value estimation techniques, substantiated, in part, by their audited financial statements and supported by the due diligence of the Company's investment management. Unrealized gains (losses) from fair value fluctuations on investments are included in the statement of activities in the period that such fluctuations occur.

Property and Equipment

Property and equipment are recorded at cost. Major additions, betterments and renewals are capitalized. The accrual method is used to recognize the costs incurred for the overhaul of helicopter engines based on estimated hours of engine use. At September 30, 2022 flight volumes, the Company will have a liability of the overhaul costs of several components on the helicopters. As a result, the accrued expense was \$539,000 and \$26,000 as of September 30, 2022 and 2021, respectively.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

Maintenance and repairs other than overhaul expenses are charged to operating expenses as they are incurred. For all property and equipment except aircraft and related components, depreciation and amortization are computed on the straight-line basis over the estimated useful lives of the related assets. The Company's depreciation policy regarding aircraft and related components is to depreciate on the straight-line basis the medical interior and equipment over five years, the avionics and electronics system over 10 years, the cost of the frame and hull over 15 years, engine overhauls over three years and the software and computer equipment over three years.

At the time assets are retired or otherwise disposed of, the cost and accumulated depreciation and amortization are removed from the respective accounts, and the difference, net of proceeds, is recorded as a gain or loss. The Company recognized a net gain of \$24,684 and \$29,859 on the disposal of assets for the years ended September 30, 2022 and 2021 respectively.

Long-lived assets to be held and used are reviewed for impairment whenever events or changes in circumstances indicate that the related carrying amount may not be recoverable. When required, impairment losses on assets to be held and used are recognized based on the fair value of the assets. There was no impairment loss recorded in 2022 or 2021.

Revenue

In May 2014, the Financial Accounting Standards Board (FASB) issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, as amended by ASU 2016-20. The core principle of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Company adopted the new standard effective October 1, 2020, using the modified retrospective method for all contracts. Under the modified retrospective method, there is no material effect to the Company's financial statements.

The Company's accounting policy has been updated to align with the new standard to recognize revenue when the following criteria are met: 1) Contract with the customer has been identified; 2) Performance obligations in the contract have been identified; 3) Transaction price has been determined; 4) Transaction price has been allocated to the performance obligations; and 5) Revenue is recognized when (or as) performance obligations are satisfied.

Net revenue from contracts with customers is recognized in the period performance obligations are satisfied under its contracts by transferring services to its patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided in accordance with ASU 2014-09.

Net Patient Service Revenue

The net patient service revenue stream has a single performance obligation to provide medical transportation services in emergency and non-emergency situations, which is satisfied at the point in-time the transport is complete (i.e. patient is delivered to destination). Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The transaction price for net patient service revenue includes gross charges for the services provided, reduced by estimates for explicit and implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors, and membership adjustments. The Company entered into payor agreements with Aetna, United Healthcare, and Baylor, Scott, & White Health Plan. These agreements specify the rates at which the payors will pay based on the location in which the transport originates, the distance of transport, method of transport services provided, and type of medical services provided. The Company does have net patient service revenue from services provided to Medicare and Medicaid program beneficiaries, which are paid at prospectively determined rates per patient transport.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

These rates vary according to a classification system that is based on the location in which the transport originates, the distance of transport, method of transport services provided, and type of medical services provided.

Revenue under third-party payor arrangements (Medicaid and Medicare) is subject to audit and retroactive adjustment. Provisions for third-party payor settlements are provided in the period the related services are rendered, and any retroactive adjustments as a result of audit are recorded in the period they become known. There were no retroactive adjustments for the years ended September 30, 2022 or 2021.

When a transport occurs, the Company identifies whether the patient is a member of the Company's program or not. If the patient is deemed to be a member, the Company bills the appropriate payor (i.e., commercial insurance, Medicare, Medicaid, etc.) Once the claim is accepted by the payor the balance bill that would be due from the patient is written off to membership absorption. If the patient is a private pay, no insurance, then the Company reduces the amount owed by 50%.

Implicit price concessions include discounts provided to self-pay, uninsured patients, or other payors as well as adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Implicit price concessions are recorded in revenue adjustments for the period. After the explicit concessions are determined, the transport charges can be modified for implicit concessions for the amount that the company ultimately expects to collect.

For each transport, the Company bills out the amount that it expects to receive as consideration. At the end of each reporting period the Company applies a reserve to the revenue to ensure that the most accurate transaction revenue is being reflected in the revenue recognition process. The reserve is based upon the payor category the transport billing falls into. The categories are: commercial, Medicaid, Medicare, private pay, and sponsor. Each category has a different percentage of reserve that is applied the day the bill is sent. These reserve percentages are reviewed regularly.

Net revenue includes provision for bad debts net of recoveries in the amounts of \$55,351,680 and \$47,626,242 for the fiscal years ending September 30, 2022 and 2021, respectively.

Charity Care

The Company provides care to patients who lack financial resources and are deemed to be medically or financially indigent. Because the Company does not pursue collection of amounts determined to qualify as charity care, these amounts have been excluded from net patient service revenue. The charges related to this care were approximately \$665,000 and \$460,000 in 2022 and 2021, respectively. The Company uses a cost-to-charge ratio to estimate the cost of charity care. The estimated cost of charity is approximately \$642,000 and \$421,000 for the years ended September 30, 2022 and 2021, respectively.

Other Revenue

Other revenue consists of wheelchair transfers, donations, Caring Heart memberships, promotional revenue from vendors for conferences hosted by the Company, and revenue received from participants enrolled in educational programs that are hosted by the Company.

Wheelchair revenue is treated the same as patient revenue. Wheelchair has its own base charge and mileage rate. These transports can be entered into by a call from the patient and/or a facility.

Membership revenue is derived from residents in close proximity to the Company's service areas paying a 1 to 5-year membership fee that provides an explicit concession described in the note above. The revenue is recorded in a deferred revenue account to be recognized in equal amounts over the time of the membership. The performance obligation of the Company is to adhere to the agreement entered into with the member if the patient utilizes the Company's service during the active time of the membership.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

The Company also enters into contracts with counties and municipalities to provide 911 services for the specific area stipulated in the contract. The performance obligation for the Company is to provide the dispatch and ambulatory services for the area during the time of contract. These contracts are detailed in Note J - Commitments and Contingencies.

Heart shop sales and sales from promotional events, are both sales of physical Company apparel and items that are sold point of sale. These sales make up less than 3% of the other revenue balance.

Contributions and Grants

All contributions are available for unrestricted use unless specifically restricted by the donor. Gifts of cash and other assets are presented as restricted support if they are received with donor stipulations that limit the use of the donated assets or if they have a time constraint. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions.

Contributions, including unconditional promises to give, are recognized as revenues in the period received. Conditional promises to give are not recognized until they become unconditional, that is, at the time when the conditions on which they depend are substantially met. Contributions with donor-imposed restrictions whose restrictions are satisfied in the same period are reported as without restrictions.

The activities directly related to patient healthcare services are included in the revenue and other support sections of the statements of operations. The income and expenses that are not directly related to patient healthcare services are included in the non-operating income (expense) section of the statements of operations and changes in net assets. As such, grant funds received under the Coronavirus Aid, Relief, and Economic Security ("CARES") Act (see Note M - Impact of Coronavirus (COVID-19)) are included in the contributions and grants within the non-operating income (expense) section.

Advertising Costs

The Company's policy is to expense all advertising costs when incurred. Advertising expense was approximately \$327,000 and \$338,000 for the years ended September 30, 2022 and 2021, respectively.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

U.S. Income Tax Status

The Company is exempt from federal income taxes under Section 501(a) of the Internal Revenue Code ("IRC") of 1986, as amended, as an organization described in Section 501(c)(3) of the IRC, and as such, contributions to the Company qualify for deduction as charitable contributions. As of September 2, 2014, the Company has been classified as a public charity under IRC Section 509(a)(2).

Additionally, any income generated from activities unrelated to the Company's exempt purpose is subject to tax under IRC Section 511. However, the Company did not have any unrelated business income tax liability or expense for the years ended September 30, 2022 and 2021.

No tax accrual for uncertain tax positions has been recorded in the accompanying statements of financial position as management believes there are no uncertain tax positions for the Company.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

Upcoming Accounting Pronouncements

In February 2016, the FASB issued ASU 2016-02, *Leases* ("ASU 2016-02"), providing authoritative guidance that requires the balance sheet recognition of lease assets and lease liabilities by lessees for leases previously classified as operating leases under prior U.S. GAAP. In June 2020, FASB issued ASU 2020-05, *In Response to Coronavirus*, to allow nonpublic entities that have not yet issued financial statements, including not-for-profit, to defer the effective date for the leasing (Topic 842) guidance for one year. Therefore, the Company will be required to adopt the new standard in annual periods beginning after December 15, 2021. Lessees and lessors will be required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach. The Company is continuing to evaluate the standard and do not expect it to have material impact on its financial statements.

NOTE B - PROPERTY AND EQUIPMENT

Major classifications of property and equipment and their estimated service lives are summarized below as of September 30:

	Estimated Service Life	2022	2021
Buildings and improvements	20 years	\$ 2,975,790	\$ 2,829,116
Movable equipment	4 to 12 years	16,604,785	15,633,773
Software and computer equipment	3 years	3,745,463	3,517,311
Aircraft and related components	3 to 15 years	37,621,322	36,633,378
Ambulances	3 to 4 years	15,583,677	15,104,903
Property and equipment		76,531,037	73,718,481
Less accumulated depreciation and amortization		(40,963,996)	(39,090,348)
Property and equipment, net		\$ 35,567,041	\$ 34,628,133

The Company has a fixed asset holding account for items that have been purchased but not yet placed into service. These items are appropriately not being depreciated. The items in this account have been allocated to each respective major classification of property and equipment above. The Company had \$2,804,414 and \$1,704,599 in the fixed asset holding account as of September 30, 2022 and 2021, respectively.

NOTE C - NET PATIENT SERVICE REVENUE AND ACCOUNTS RECEIVABLE

Changes in the Company's allowance for doubtful accounts were as follows for the years ended:

	2022	2021
Beginning balance	\$ 35,595,280	\$ 25,349,223
Provision for bad debts, net of recoveries	55,351,955	47,650,895
Write offs	(48,929,722)	(37,404,838)
Ending balance	\$ 42,017,513	\$ 35,595,280

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

The composition of gross patient accounts receivable, net of contractual allowances, was as follows at September 30:

	2022	2021
Commercial	47%	49%
Private pay	46	43
Medicare	5	6
Medicaid	2	2
	<u>100%</u>	<u>100%</u>

Commercial receivables consist of receivables from various payors involved in diverse activities and subject to differing economic conditions and do not represent any concentrated credit risks to the Company. Furthermore, management continually monitors and adjusts its allowance associated with its receivables.

Write-offs from accounts receivable are generated from patient deductibles and coinsurance as well as patients with no source of third-party coverage. The chart below displays the write-offs from the patient's primary payor source:

	2022	2021
Commercial	34%	35%
Private pay	62	62
Medicare	4	3
	<u>100%</u>	<u>100%</u>

The following table reflects percentages of patient service revenue, net of contractual and other adjustments, but before the provision for bad debts:

	2022	2021
Commercial	49%	55%
Private pay	28	23
Medicare	21	20
Medicaid	2	1
	<u>100%</u>	<u>100%</u>

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

NOTE D - LONG-TERM DEBT

Long-term debt consisted of the following at September 30:

	2022	2021
Note payable to Bank of Texas dated April 3, 2020, in the amount of \$4,585,099, monthly payments of \$30,846; including interest at 2.59%; through April 3030. (Two Bell 407 helicopters)	\$ 3,958,124	\$ 4,220,288
Note payable to Clayton Holding, LLC (Commerce Bank) dated February 12, 2016, in the amount of \$6,934,484; monthly payments of \$47,942 beginning September 15, 2016; including interest at 2.373% through January 15, 2026 with a balloon payment of \$2,752,445. (Bell 429 helicopter)	4,347,070	4,812,333
Note payable to People's Capital (Refinance Textron Note) dated December 21, 2017 for \$3,549,736; monthly payment of \$30,089 beginning January 21, 2018; interest at 3.42% through December 2027. (Bell 407 helicopter)	2,315,539	2,592,262
Note payable to People's Capital (Refinance Commerce Note) dated March 31, 2020 for \$5,082,243; monthly payment of \$40,657.25 beginning April 30, 2020; interest at 2.47% through March 2030. (Bell 429 helicopter)	4,128,185	4,509,150
Note payable to Zoll (Equipment Note) dated March 1, 2019 for \$1,655,465; monthly payment of \$25,246 beginning March 1, 2018; interest at 0% through February 2023	126,296	429,444
Note payable to Zoll (Equipment Note) dated January 25, 2019 for \$234,250; monthly payment of \$6,512 beginning January 25, 2019; interest at 0% through December 2021	-	19,349
Note payable to Zoll (Equipment Note) dated March 6, 2019 for \$286,240; monthly payment of \$7,949 beginning March 6, 2019; interest at 0% through January 2022	-	31,804
Note payable to Zoll (Equipment Note) dated October 17, 2019 for \$413,664; monthly payment of \$11,500 beginning October 17, 2019; interest at 0% through September 2022	-	137,674
Note payable to Bank of Texas (Equipment Note) dated September 9, 2018 for \$2,500,000; monthly payment of \$48,089 beginning October 9, 2018; interest at 5.71% through September 2023	559,961	1,087,952
Note payable to Frost Bank (Refinance Commerce Note) dated April 3, 2020 for \$4,503,307; monthly payment of \$30,538 beginning May 3, 2020; interest at 2.70% through April 3030 (Two Bell 407 helicopters)	3,896,771	4,152,750
Total	19,331,946	21,993,006
Less: unamortized debt issuance costs	-	(32,380)
Less: discount on Zoll financing	(1,358)	(17,477)
Total debt	19,330,588	21,943,149
Current portion	2,371,458	2,649,621
Long-term debt	\$ 16,959,130	\$ 19,293,528

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

The Bank of Texas and Commerce Bank notes are governed by Promissory Notes and Business Loan Agreements for a security interest in ambulances, medical equipment, and helicopters and are subject to a fixed-charge-coverage-ratio financial covenant quarterly. As of each quarter and for the fiscal year ended September 30, 2022, the Company was in compliance with all debt covenant requirements.

The following is a summary of the future maturities of long-term debt for the years ending September 30:

2023	\$	2,372,816
2024		1,731,618
2025		1,778,976
2026		4,194,012
2027		1,351,736
Thereafter		<u>7,902,788</u>
	\$	<u>19,331,946</u>

Effective June 12, 2020, the Company increased the line of credit with Bank of Texas from \$2,000,000 to \$2,500,000. The term is for one year with the intent to renew each year in June. The loan can be used for working capital and general corporate purposes. The interest rate is variable with a current index of 4%. There was no balance due at September 30, 2022. The Company has long-term financing arrangements, with 0% interest, with Zoll Medical Corp. and Zoll Data Solutions. Per the nature of the financings, the Company imputed interest based on the most recent financing the Company had entered into with a bank, 4.3%. The Company had discounts recorded of \$1,358 and \$17,477 for the years ended September 30, 2022 and 2021, respectively.

NOTE E - ACCRUED LIABILITIES

Accrued liabilities consist of the following at September 30:

	2022	2021
Interest payable	\$ 23,730	\$ 27,450
Accrued payables	1,032,642	628,897
Payroll and benefits	<u>4,505,914</u>	<u>5,143,884</u>
Total accrued liabilities	\$ 5,562,286	\$ 5,800,231

NOTE F - RETIREMENT PLAN

The Company sponsors the CareFlite 401(k) Plan (the "Plan") covering all employees. Employees are eligible to participate in the Plan immediately upon hire, however, they do not receive an employer match until they have worked one full year with the Company. Employee contributions to the Plan are 100% vested and cannot exceed the maximum allowable deductions permitted under Section 401 of the IRC. The Company will match up to 125% of the employee's contributions up to a maximum employer contribution of 6% of the employee's salary. Company contributions vest based on the number of years of service. Total contributions made by the Company to the Plan during the years ended September 30, 2022 and 2021 were \$1,672,617 and \$1,637,201, respectively.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

NOTE G - OPERATING LEASES

The Company leases various equipment and facilities under leases classified as operating leases, some of which include provisions for escalation clauses. Total rent for these leases charged to expense in the years ended September 30, 2022 and 2021 was \$524,943 and \$511,680, respectively.

The future minimum rental payments required under the operating leases are as follows for the years ending September 30:

2023	\$	238,467
2024		125,606
2025		109,491
2026		106,203
2027		71,633
Thereafter		<u>1,612,573</u>
	<u>\$</u>	<u>2,263,973</u>

NOTE H - FUNCTIONAL EXPENSES

The Company provides medical transportation services to residents within its geographic area. General and administrative expenses for each program include onboarding costs, uniforms, certifications, training/licenses, various office supplies, travel/meeting expenses, printing, postage, telephone/internet, utilities, janitorial services, building repairs, building supplies, employee awards/gifts, and safety expenses. Certain expenses for the Fixed Wing program and Helicopter program are allocated based on patient revenue percentage. The majority of the expenses are directly accounted for in each individual program. Expenses related to providing these services are as follows for the year ended September 30, 2022:

	Programs			Supporting Services		Total Expenses
	Fixed Wing	Helicopter Operations	Ground Operations	Operation Center	General and Administrative	
Salaries and benefits	\$ 633,117	\$ 12,378,846	\$ 30,709,704	\$ 2,716,367	\$ 4,351,816	\$ 50,789,850
General and administrative	25,029	584,430	1,887,776	290,102	1,134,768	3,922,105
Billing fee	39,815	1,123,265	1,683,051	-	-	2,846,131
Operating	110,875	440,352	1,479,176	50,927	14,893	2,096,223
Fuel	198,098	1,041,186	1,945,560	-	37,493	3,222,337
Marketing and advertising	70	27,463	90,439	966	417,406	536,344
Insurance	97,409	1,444,378	1,190,811	2,703	960,012	3,695,313
Purchased service	14,881	388,266	933,818	73,977	1,555,704	2,966,846
Maintenance	285,250	3,501,608	1,093,349	795	26,322	4,907,324
Amortization and depreciation	84,972	859,136	1,062,815	427,044	1,146,290	3,580,257
	<u>\$ 1,489,515</u>	<u>\$ 21,788,931</u>	<u>\$ 42,076,499</u>	<u>\$ 3,562,881</u>	<u>\$ 9,644,704</u>	<u>\$ 78,562,530</u>

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

Expenses related to providing medical transportation services are as follows for the year ended September 30, 2021:

	Programs			Supporting Services		Total Expenses
	Fixed Wing	Helicopter Operations	Ground Operations	Operation Center	General and Administrative	
Salaries and benefits	\$ 971,312	\$ 11,345,891	\$ 30,506,880	\$ 2,519,109	\$ 4,261,159	\$ 49,604,461
General and administrative	95,740	565,116	1,896,632	202,317	857,290	3,417,095
Billing fee	50,255	1,126,206	1,576,448	-	-	2,752,909
Operating	150,919	454,811	1,410,541	62,009	8,013	2,086,290
Fuel	212,705	522,639	1,354,441	1,722	10,553	2,102,060
Marketing and advertising	126	24,885	98,597	1,485	303,164	428,257
Insurance	131,304	1,317,349	1,117,028	3,802	879,973	3,449,456
Purchased service	26,836	528,752	1,009,861	98,639	1,442,022	3,106,210
Maintenance	306,028	2,348,615	1,103,738	13,234	10,559	3,762,224
Amortization and depreciation	133,534	1,160,009	758,166	465,706	974,539	3,511,954
	<u>\$ 2,078,759</u>	<u>\$ 19,414,273</u>	<u>\$ 40,632,592</u>	<u>\$ 3,368,020</u>	<u>\$ 8,747,272</u>	<u>\$ 74,240,916</u>

NOTE I - RELATED PARTIES

Included in patient accounts receivable at September 30, 2022 and 2021 is \$1,456,869 and \$1,749,066, respectively, due from the Company's Members relating primarily to patient billing, which will be reimbursed to the Company directly from the Members.

NOTE J - COMMITMENTS AND CONTINGENCIES

The Company purchases professional and general liability insurance to cover medical malpractice claims. There are no known incidents that may result in the assertion of additional claims. Management is not aware of any claims or contingencies that would be material to the financial position or results of operations of the Company.

The healthcare industry is subject to numerous laws and regulations of Federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulation by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Company is in compliance with antifraud and abuse statutes as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions, unknown or unasserted at this time.

On November 1, 2008, the Company entered into an agreement with the Ellis County Emergency Services District No. 5 ("ESD 5") to be the primary ambulance provider for 911 services within the district. ESD 5 includes the City of Ferris, which provides a subsidy of \$36,000 per year. The agreement was renewed in October 2013 and October 2018 for another five years at \$36,000 per year.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

On October 1, 2009, the Company entered into an agreement with Hill County Emergency Services District No. 2 ("ESD 2") to be the primary commercial ambulance provider for 911 services within the ESD 2. The term of the agreement is for five years and includes a \$600,000 per year cost sharing subsidy. Amendment 8 extended the term of the contract to September 30, 2027 with \$730,462 for October 2019 through September 2020, and each subsequent year to have an increase by 2% over the previous fiscal year or by 2% plus have of inflation in the previous fiscal year if inflation is 4% or greater.

On October 1, 2009, the Company entered into an agreement with the City of Balch Springs to be the primary commercial ambulance provider for 911 services within the city. On October 1, 2018, the agreement was amended and the services renewed until September 30, 2022 at \$150,000 per year. On October 1, 2021, the agreement was amended and the services renewed until September 30, 2023 at \$225,000 from October 1, 2021 through September 30, 2022 and \$300,000 from October 1, 2022 through September 30, 2023.

NOTE K - CAPITAL CONTRIBUTIONS

Periodically during the year, the Company receives unrestricted contributions. These amounts for the years ended September 30, 2022 and 2021 were approximately \$36,000 and \$42,200, respectively. In 2015, the Company received a restricted contribution in the amount of \$254,000 for the purchase of specific medical equipment, of which the balance was included in net assets with donor restrictions on the statement of financial position as of September 30, 2021 and was released from restrictions during the fiscal year ended September 30, 2022.

NOTE L - LIQUIDITY AND AVAILABILITY OF RESOURCES

The following table reflects the Company's financial assets as of September 30, 2022 and 2021, that are available for general expenditure within one year. Financial assets are considered unavailable when illiquid or not convertible to cash within one year or are restricted funds.

	2022	2021
Financial assets:		
Cash and cash equivalents	\$ 21,080,462	\$ 42,557,762
Short Term Investments	15,685,330	-
Patient accounts receivable, net, due within one year	20,025,316	21,095,111
Accounts receivable - non-patient	266,027	205,350
	57,057,135	63,858,223
Less amounts unavailable for general expenditure within one year due to:		
Estimated settlement due to third party payors	-	(1,473,678)
Financial assets available to meet cash needs for general expenditure within one year	\$ 57,057,135	\$ 62,384,545

The Company also has an unsecured \$2,500,000 line of credit, which it could draw upon in the event of an anticipated liquidity need.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2022 and 2021

NOTE M - IMPACT OF CORONAVIRUS (COVID-19)

COVID-19 has been declared a global health pandemic by the World Health Organization. COVID-19 led to the implementation of significant, government-imposed measures to prevent or reduce its spread, including travel restrictions, "shelter in place" orders, and business closures. As a result, the Company experienced an unprecedented decline in trip volume during the months of March, April, and May of 2020. This directly resulted in the Company's total operating revenues decreasing approximately 19% in March 2020, 27% in April 2020, and 17% in May 2020 over the same months in 2019. To mitigate the losses, the Company participated in several programs available through the CARES Act.

The Company received grant funds from the Department of Health and Human Services' ("HHS") Provider Relief Fund ("PRF"), of \$0 and \$1,622,657 as of September 30, 2022 and 2021, respectively. The requirements for acceptance of the funds state that the Company must use the funds for COVID-19 related expenses, or to offset lost revenue due to the COVID-19 pandemic. These funds are subject to audit and compliance with federal regulations. Per review of the grant fund regulations, the Company believes it has met the conditions to retain these funds, and no amounts are reserved for repayment at September 30, 2022 and 2021 in the accompanying statement of financial position. This amount is recognized in contributions and grants revenue in the statement of operations and changes in net assets.

The CARES Act also provided for an expansion of the Medicare Accelerated and Advance Payment Program for patient services. Under this program the Company received \$2,767,277 in April 2020 and recorded the payments in accrued liabilities on the statement of financial position. Prior to the beginning of the recoupment period, the Company continues to bill for services provided to Medicare patients and was paid by Medicare, as usual. The recoupment period began in April 2021. During the recoupment period, amounts billed to Medicare for services provided are offset against the advance payments received until the advance is fully recouped by the Medicare program. The Company will have one year to offset future claims against the advance. If the advance has not been entirely offset by claims at the end of this period, the Company will be required to repay the remaining amount. The remaining amount to be recouped as of September 30, 2022 is \$0.

On May 13, 2020, February 3, 2021 and April 20, 2021 the Company entered into Payroll Support Program Agreements ("PSPs") with the Treasury pursuant to the CARES Act. The PSP funds are required to be exclusively used for employee wages, salaries, and benefits, with further requirements against furloughs and reductions in employee pay rates and benefits until after the date of September 30, 2022. The PSPs require quarterly reporting obligations through the year 2022. Through the PSP Agreements, the Company received \$0 and \$20,278,742 during the years ended September 30, 2022 and 2021, respectively. The Company has, per the conditions and requirements of the PSP, used the funds accordingly and in their entirety before September 30, 2022. There are no funds reserved on the statement of financial position, and all the funds are reflected on the statement of operations and changes in net assets as contributions and grants revenue.

NOTE N - SUBSEQUENT EVENTS

The Company has evaluated subsequent events through December 7, 2022, the date the financials were available to be issued, and has determined there are no additional material subsequent events or transactions that would require additional disclosure in the Company's financial statements.

4. Financial Statements and Report of Independent Certified Public Accounts 2023

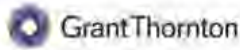
Financial Statements and Report of
Independent Certified Public
Accountants

CareFlite

September 30, 2023 and 2022

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors
CareFlite

Opinion

We have audited the financial statements of CareFlite (the "Entity"), which comprise the statements of financial position as of September 30, 2023 and 2022, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Entity as of September 30, 2023 and 2022, and the results of its operations and changes in net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for opinion

We conducted our audits of the financial statements in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Entity and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of matter

As discussed in Note A and Note J of the financial statements, the Entity has adopted new accounting guidance in 2023 related to the accounting for leases. Our opinion is not modified with respect to this matter.

Responsibilities of management for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Entity's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Entity's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Grant Thornton LLP

Dallas, Texas
December 13, 2023

CareFlite

STATEMENTS OF FINANCIAL POSITION

September 30,

	2023	2022
ASSETS		
Current assets		
Cash and cash equivalents	\$ 11,152,944	\$ 21,080,462
Investments	18,152,700	15,685,330
Patient accounts receivable, net of allowance for doubtful accounts of \$35,363,062 and \$42,017,513	17,608,562	20,025,316
Accounts receivable - non-patient	284,146	266,027
Inventories	668,600	623,624
Prepaid expenses and deposits	1,556,186	1,491,256
Total current assets	49,423,138	59,172,015
Property and equipment, net	42,243,788	35,567,041
Right of use assets, net	2,539,722	-
Total assets	<u>\$ 94,206,648</u>	<u>\$ 94,739,056</u>
LIABILITIES AND NET ASSETS		
Current liabilities		
Current maturities of long-term debt, net	\$ 1,731,619	\$ 2,371,458
Current right of use liability	920,800	-
Accounts payable	2,124,849	1,585,353
Current deferred revenue	394,638	412,241
Accrued liabilities	5,846,822	5,562,286
Total current liabilities	11,018,728	9,931,338
Long-term liabilities		
Long-term debt, net	16,227,205	16,959,130
Long-term right of use liability	4,003,702	-
Long-term deferred revenue	687,740	653,946
Total long-term liabilities	19,918,647	17,613,076
Total liabilities	30,937,375	27,544,414
Commitments and contingencies		
Net assets		
Net assets without donor restrictions	63,269,273	67,194,642
Total net assets	63,269,273	67,194,642
Total liabilities and net assets	<u>\$ 94,206,648</u>	<u>\$ 94,739,056</u>

The accompanying notes are an integral part of these financial statements.

CareFlite

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

For the years ended September 30,

	2023	2022
Revenue and other support		
Net patient service revenue, net of provision for bad debt and recoveries	\$ 71,805,635	\$ 78,846,452
Other revenue	4,722,771	4,589,501
Net assets released from restriction	-	33,059
Total unrestricted revenue and other support	76,528,406	83,469,012
Expenses		
Programs:		
Fixed wing	1,120,142	1,489,515
Helicopter operations	24,159,004	21,788,931
Ground operations	42,727,283	42,076,499
Supporting services:		
Operations center	4,001,398	3,562,881
General and administrative	10,904,521	9,644,704
Total expenses	82,912,348	78,562,530
Income (loss) from operations	(6,383,942)	4,906,482
Nonoperating income (expense)		
Contributions and grants	32,477	36,054
Interest expense, net	(169,320)	(526,433)
Unrealized net gain/(loss) on investments	2,467,370	(4,314,865)
Net gain on disposal of property and equipment	128,046	24,684
Total nonoperating income (expense)	2,458,573	(4,780,560)
Change in net assets without donor restrictions	(3,925,369)	125,922
Changes in net assets with donor restrictions		
Net assets released from restriction	-	(33,059)
Change in net assets with donor restrictions	-	(33,059)
CHANGE IN NET ASSETS	(3,925,369)	92,863
Net assets, at beginning of year	67,194,642	67,101,779
Net assets, at end of year	\$ 63,269,273	\$ 67,194,642

The accompanying notes are an integral part of these financial statements.

CareFlite

STATEMENTS OF CASH FLOWS

For the years ended September 30,

	2023	2022
Cash flows from operating activities:		
Change in net assets	\$ (3,925,369)	\$ 82,863
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	3,673,346	3,547,877
Amortization of debt issuance costs	-	32,380
Provision for bad debts	42,360,919	55,351,955
Net gain on disposal of property and equipment	(128,046)	(24,684)
Amortization of right of use asset	13,571	-
Unrealized (gain) loss on investments	(2,467,370)	4,314,870
Interest on finance lease liability	(100,582)	-
Change in assets and liabilities:		
Patient accounts receivable	(39,944,165)	(54,282,160)
Accounts receivable - non-patient	(18,119)	(60,677)
Inventories	(44,976)	5,600
Prepaid expenses and deposits	(64,930)	(129,516)
Accounts payable	539,496	(731,051)
Deferred revenue	16,191	(808,951)
Accrued liabilities	284,536	(1,711,623)
Net cash provided by operating activities	194,502	5,596,683
Cash flows from investing activities:		
Purchase of property and equipment	(7,570,219)	(4,486,785)
Proceeds from disposal of property and equipment	128,046	24,684
Purchase of investments	-	(20,000,000)
Net cash used in investing activities	(7,442,173)	(24,462,101)
Cash flows from financing activities:		
Payments on long-term debt	(2,371,764)	(2,644,941)
Payments on finance lease obligation	(308,083)	-
Net cash used in financing activities	(2,679,847)	(2,644,941)
Net decrease in cash and cash equivalents	(9,927,518)	(21,510,359)
Cash and cash equivalents at beginning of year	<u>21,080,462</u>	<u>42,590,821</u>
Cash and cash equivalents at end of year	<u>\$ 11,152,944</u>	<u>\$ 21,080,462</u>
Supplemental disclosures of cash flow information:		
ROU assets obtained in exchange for operating lease obligations	\$ 870,177	\$ -
Operating lease expense	548,206	524,943
Interest paid	591,093	581,248

The accompanying notes are an integral part of these financial statements.

CareFlite

NOTES TO FINANCIAL STATEMENTS

September 30, 2023 and 2022

NOTE A - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

CareFlite (the "Company"), a 501(c)(3) tax-exempt corporation, operates a helicopter, fixed wing, and ground ambulance service in Dallas and Fort Worth, Texas, and the surrounding communities. Texas Health Resources ("THR"), Baylor University Medical Center ("BUMC") and Methodist Hospitals of Dallas ("MHD"), (collectively, the "Members") have member interests of 50%, 25% and 25%, respectively, in the Company. Dallas County Hospital District d/b/a Parkland Health and Hospital System ("DCHD") and John Peter Smith Hospital ("JPSH") are special affiliates with no membership interest.

The Board of Directors (the "Board") consists of twelve voting members. The President of the Company and the Medical Director are nonvoting members of the Board. THR has four voting members, BUMC has two voting members, MHD has two voting members, DCHD has two voting members, and JPSH has two voting members.

Basis of Presentation

The accompanying financial statements were prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP").

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets of the Company and changes therein are classified as follows:

Net Assets Without Donor Restrictions - Net assets that are not subject to donor-imposed stipulations. Unrestricted net assets may be designated for specific purposes by action of the Board.

Net Assets with Donor Restrictions - Net assets subject to donor-imposed stipulations that may or will be met by the occurrence of a specific event or the passage of time. When a donor restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions. Contributions with donor-imposed restrictions whose restrictions are satisfied in the same period are reported as released from restrictions in that period. The Company did not have any net assets with donor restrictions as of September 30, 2023 and 2022.

Cash and Cash Equivalents

The Company considers all highly liquid investments with a maturity of 90 days or less at the time of purchase to be cash equivalents. Cash and cash equivalents include cash held in banks and money market accounts. Cash equivalents are carried at cost, which approximates fair value due to their short-term nature. The Company's cash and cash equivalents are placed with high-credit-quality financial institutions, and at times may exceed insured limits. The Company has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk.

Accounts Receivable

Accounts receivable is recorded net of an allowance for doubtful accounts and contractual adjustments (which represent the difference between list charges and the amount received or receivable from third-party payors). The allowance for doubtful accounts is provided based on management's judgment, including such factors as payer type and prior collection history. Accounts are deemed by management to be uncollectible after 150 days and are written off at that time. Payments subsequently received on such receivables are credited to the allowance for doubtful accounts.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

On January 1, 2022 the No Surprise Billing Act went into effect. The act bans balanced billings from out of network air providers to patients who have certain insurances. It also requires the insurance companies and providers, who are not in network with one another, to negotiate a payment amount. If during this negotiation period no amount is agreed upon, the provider may initiate the Federal Independent Dispute Resolution (IDR) process, in which an arbitrator will rule on the amount to be paid. The Company reserves the accounts receivable based on the current policies in place.

Inventories

Inventories consist of rotatable aircraft and helicopter parts, expendable parts and supplies used in treating patients. The inventory and aircraft supplies are carried at the lower of cost using the first-in, first-out method or net realizable value.

Investments

All investments are carried at fair value. Fair values of investments in a balanced pool fund that have limited marketability are based on net asset value ("NAV") as a practical expedient in estimating fair value. The NAVs are determined by the fund manager or general partner based on their best estimates using fair value estimation techniques, substantiated, in part, by their audited financial statements and supported by the due diligence of the Company's investment management. Unrealized gains (losses) from fair value fluctuations on investments are included in the statements of operations and changes in net assets in the period that such fluctuations occur.

Property and Equipment

Property and equipment are recorded at cost. Major additions, betterments and renewals are capitalized. The accrual method is used to recognize the costs incurred for the overhaul of helicopter engines based on estimated hours of engine use. At September 30, 2023 flight volumes, the Company will have a liability of the overhaul costs of several components on the helicopters. As a result, the accrued expense was \$740,000 and \$639,000 as of September 30, 2023 and 2022, respectively.

Maintenance and repairs other than overhaul expenses are charged to operating expenses as they are incurred. For all property and equipment except aircraft and related components, depreciation and amortization are computed on the straight-line basis over the estimated useful lives of the related assets. The Company's depreciation policy regarding aircraft and related components is to depreciate on the straight-line basis for the medical interior and equipment over five years, the avionics and electronics system over 10 years, the cost of the frame and hull over 15 years, engine overhauls over three years and the software and computer equipment over three years.

At the time assets are retired or otherwise disposed of, the cost and accumulated depreciation and amortization are removed from the respective accounts, and the difference, net of proceeds, is recorded as a gain or loss. The Company recognized a net gain of \$128,046 and \$24,684 on the disposal of assets for the years ended September 30, 2023 and 2022, respectively.

Long-lived assets to be held and used are reviewed for impairment whenever events or changes in circumstances indicate that the related carrying amount may not be recoverable. When required, impairment losses on assets to be held and used are recognized based on the fair value of the assets. There was no impairment loss recorded in 2023 or 2022.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

Revenue

The Company's accounting policy is to recognize revenue when the following criteria are met: 1) Contract with the customer has been identified; 2) Performance obligations in the contract have been identified; 3) Transaction price has been determined; 4) Transaction price has been allocated to the performance obligations; and 5) Revenue is recognized when (or as) performance obligations are satisfied.

Net revenue from contracts with customers is recognized in the period performance obligations are satisfied under its contracts by transferring services to its patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided.

Net Patient Service Revenue

The net patient service revenue stream has a single performance obligation to provide medical transportation services in emergency and non-emergency situations, which is satisfied at the point in-time the transport is complete (i.e. patient is delivered to destination). Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. The transaction price for net patient service revenue includes gross charges for the services provided, reduced by estimates for explicit and implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors, and membership adjustments. The Company entered into payor agreements with Aetna, United Healthcare, and Baylor, Scott, & White Health Plan. These agreements specify the rates at which the payors will pay based on the location in which the transport originates, the distance of transport, method of transport services provided, and type of medical services provided. The Company does not have net patient service revenue from services provided to Medicare and Medicaid program beneficiaries, which are paid at prospectively determined rates per patient transport.

These rates vary according to a classification system that is based on the location in which the transport originates, the distance of transport, method of transport services provided, and type of medical services provided.

Revenue under third-party payor arrangements (Medicaid and Medicare) is subject to audit and retroactive adjustment. Provisions for third-party payor settlements are provided in the period the related services are rendered, and any retroactive adjustments as a result of audit are recorded in the period they become known. There were no retroactive adjustments for the years ended September 30, 2023 or 2022.

When a transport occurs, the Company identifies whether the patient is a member of the Company's program or not. If the patient is deemed to be a member, the Company bills the appropriate payor (i.e., commercial insurance, Medicare, Medicaid, etc.). Once the claim is accepted by the payor the balance that would be due from the patient is written off to membership absorption. If the patient is a private pay, no insurance, then the Company reduces the amount owed by 50%.

Implicit price concessions include discounts provided to self-pay, uninsured patients, or other payors as well as adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Implicit price concessions are recorded in revenue adjustments for the period. After the explicit concessions are determined, the transport charges can be modified for implicit concessions for the amount that the Company ultimately expects to collect.

For each transport, the Company bills out the amount that it expects to receive as consideration. At the end of each reporting period the Company applies a reserve to the revenue to ensure that the most accurate transaction revenue is being reflected in the revenue recognition process. The reserve is based upon the payor category the transport billing falls into. The categories are: commercial, Medicaid, Medicare, private

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

pay, and sponsor. Each category has a different percentage of reserve that is applied the day the bill is sent. These reserve percentages are reviewed regularly.

Net revenue includes provision for bad debts net of recoveries in the amounts of \$42,360,919 and \$65,351,680 for the fiscal years ending September 30, 2023 and 2022, respectively.

Charity Care

The Company provides care to patients who lack financial resources and are deemed to be medically or financially indigent. Because the Company does not pursue collection of amounts determined to qualify as charity care, these amounts have been excluded from net patient service revenue. The charges related to this care were approximately \$511,000 and \$665,000 in 2023 and 2022, respectively. The Company uses a cost-to-charge ratio to estimate the cost of charity care. The estimated cost of charity is approximately \$538,000 and \$642,000 for the years ended September 30, 2023 and 2022, respectively.

Other Revenue

Other revenue consists of wheelchair transfers, donations, Caring Heart memberships, promotional revenue from vendors for conferences hosted by the Company, and revenue received from participants enrolled in educational programs that are hosted by the Company.

Wheelchair revenue is treated the same as patient revenue. Wheelchair has its own base charge and mileage rate. These transports can be entered into by a call from the patient and/or a facility.

Membership revenue is derived from residents in close proximity to the Company's service areas paying a 1 to 5-year membership fee that provides an explicit concession described in the note above. The revenue is recorded in a deferred revenue account to be recognized in equal amounts over the time of the membership. The performance obligation of the Company is to adhere to the agreement entered into with the member if the patient utilizes the Company's service during the active time of the membership.

The Company also enters into contracts with counties and municipalities to provide 911 services for the specific area stipulated in the contract. The performance obligation for the Company is to provide the dispatch and ambulatory services for the area during the time of contract. These contracts are detailed in Note 1 - Commitments and Contingencies.

Heart shop sales and sales from promotional events, are both sales of physical Company apparel and items that are sold point of sale. These sales make up less than 1% of the other revenue balance.

Contributions and Grants

All contributions are available for unrestricted use unless specifically restricted by the donor. Gifts of cash and other assets are presented as restricted support if they are received with donor stipulations that limit the use of the donated assets or if they have a time constraint. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restrictions.

Contributions, including unconditional promises to give, are recognized as revenues in the period received. Conditional promises to give are not recognized until they become unconditional, that is, at the time when the conditions on which they depend are substantially met. Contributions with donor-imposed restrictions whose restrictions are satisfied in the same period are reported as without restrictions.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

Leases

Upon adoption, Accounting Standards Update ("ASU") 2016-01, *Leases (Topic 842)*, had an impact on the Company's statement of financial position and in its statement of operations and changes in net assets. As part of the transition, the Company elected the following practical expedients:

- Package of practical expedients which eliminates the need to reassess (1) whether any expired or existing contracts are or contain leases; (2) the lease classification for any expired or existing leases; and (3) the initial direct costs for any existing leases;
- The practical expedient whereby the lease and non-lease components will not be separated for all classes of assets.
- Not to recognize right-of-use (ROU) assets and corresponding lease liabilities with a lease term of 12 months or less from the lease commencement date.

For existing leases, the Company did not elect the use of hindsight and did not reassess lease term upon adoption.

The Company adjusted the opening ROU asset balance based on its remaining deferred rent liabilities. On October 1, 2022, the Company recorded \$2,155,867 in operating lease ROU and lease liability respectively. The adoption of ASC 842 had no significant impact on the Company's changes in net assets.

As of September 30, 2023, the Company has no additional operating leases that have not yet commenced.

Advertising Costs

The Company's policy is to expense all advertising costs when incurred. Advertising expense was approximately \$234,000 and \$327,000 for the years ended September 30, 2023 and 2022, respectively.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

U.S. Income Tax Status

The Company is exempt from federal income taxes under Section 501(a) of the Internal Revenue Code ("IRC") of 1986, as amended, as an organization described in Section 501(c)(3) of the IRC, and as such, contributions to the Company qualify for deduction as charitable contributions. As of September 3, 2014, the Company has been classified as a public charity under IRC Section 509(a)(2).

Additionally, any income generated from activities unrelated to the Company's exempt purpose is subject to tax under IRC Section 511. However, the Company did not have any unrelated business income tax liability or expense for the years ended September 30, 2023 and 2022.

No tax accrual for uncertain tax positions has been recorded in the accompanying statements of financial position as management believes there are no uncertain tax positions for the Company.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

Recently Adopted Accounting Standard

In February 2016, the Financial Accounting Standards Board ("FASB") issued ASU 2016-02, *Leases (Topic 842)*. This standard requires the recognition of a ROU and lease liability on the balance sheet for substantially all leases. The standard retained a dual model for lease classification, requiring leases to be classified as finance or operating lease to determine recognition in the statement of operations and cash flows. Additionally, in July 2018, the FASB issued ASU 2018-11, *Leases, Targeted Improvements*, which provided entities with a transition method option to not restate comparative periods presented, but to recognize a cumulative effect adjustment to beginning net assets in the period of adoption. The Company elected the modified retrospective transition method and did not restate prior comparative periods. The standards also provide additional transition relief, of which the Company has elected to (1) not reassess whether any expired or existing contracts are or contain leases, (2) retain the classification of leases (e.g., operating or finance lease) existing as of the date of adoption, (3) not reassess initial direct costs for any existing leases, and (4) not utilize hindsight when assessing lease term and ROU asset impairment. The standards require more detailed disclosures to enable users of financial statements to understand the amount, timing and uncertainty of cash flows arising from leases. The Company adopted this standard as of October 1, 2022.

NOTE B - PROPERTY AND EQUIPMENT

Major classifications of property and equipment and their estimated service lives are summarized below as of September 30:

	Estimated Service Life	2023	2022
Buildings and improvements	20 years	\$ 3,237,191	\$ 2,975,790
Movable equipment	4 to 12 years	18,961,301	18,604,785
Software and computer equipment	3 years	3,912,826	3,745,463
Aircraft and related components	3 to 15 years	42,326,523	37,621,322
Ambulances	3 to 4 years	17,733,808	15,583,677
Property and equipment		86,171,649	78,531,037
Less accumulated depreciation and amortization		(43,927,861)	(40,963,998)
Property and equipment, net		\$ 42,243,788	\$ 35,567,041

The Company has a fixed asset holding account for items that have been purchased but not yet placed into service. These items are appropriately not being depreciated. The items in this account have been allocated to each respective major classification of property and equipment above. The Company had \$1,882,365 and \$2,804,414 in the fixed asset holding account as of September 30, 2023 and 2022, respectively.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

NOTE C - NET PATIENT SERVICE REVENUE AND ACCOUNTS RECEIVABLE

Changes in the Company's allowance for doubtful accounts were as follows for the years ended:

	2023	2022
Beginning balance	\$ 42,017,513	\$ 35,595,280
Provision for bad debts, net of recoveries	42,360,919	55,351,955
Write offs	(49,015,370)	(48,929,722)
Ending balance	<u>\$ 35,363,062</u>	<u>\$ 42,017,513</u>

The composition of gross patient accounts receivable, net of contractual allowances, was as follows at September 30:

	2023	2022
Commercial	51%	47%
Private pay	40	46
Medicare	8	5
Medicaid	1	2
	<u>100%</u>	<u>100%</u>

Commercial receivables consist of receivables from various payors involved in diverse activities and subject to differing economic conditions and do not represent any concentrated credit risks to the Company. Furthermore, management continually monitors and adjusts its allowance associated with its receivables.

Write-offs from accounts receivable are generated from patient deductibles and coinsurance as well as patients with no source of third-party coverage. The chart below displays the write-offs from the patient's primary payor source:

	2023	2022
Commercial	30%	34%
Private pay	66	62
Medicare	4	4
	<u>100%</u>	<u>100%</u>

The following table reflects percentages of patient service revenue, net of contractual and other adjustments, but before the provision for bad debts:

	2023	2022
Commercial	48%	49%
Private pay	26	28
Medicare	24	21
Medicaid	2	2
	<u>100%</u>	<u>100%</u>

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

NOTE D - LONG-TERM DEBT

Long-term debt consisted of the following as of September 30:

	2023	2022
Note payable to Bank of Texas dated April 3, 2020, in the amount of \$4,585,099, monthly payments of \$30,846, including interest at 2.69%, through April 3030. (Two Bell 407 helicopters)	\$ 3,689,005	\$ 3,958,124
Note payable to Clayton Holding, LLC (Commerce Bank) dated February 12, 2016, in the amount of \$6,934,484, monthly payments of \$47,942 beginning September 15, 2016, including interest at 2.373%, through January 215, 2026 (with a balloon payment of \$2,752,445. (Bell 429 helicopter)	3,868,790	4,347,070
Note payable to People's Capital (Refinance Tektron Note) dated December 21, 2017 for \$3,549,736; monthly payment of \$30,089 beginning January 21, 2018; interest at 3.42% through December 2027. (Bell 407 helicopter)	2,029,613	2,315,539
Note payable to People's Capital (Refinance Commerce Note) dated March 31, 2020 for \$5,062,243; monthly payment of \$40,657.25 beginning April 30, 2020; interest at 2.47% through March 2030. (Bell 429 helicopter)	5,737,719	4,128,185
Note payable to Zoll (Equipment Note) dated March 1, 2018 for \$1,655,465; monthly payment of \$25,246 beginning March 1, 2018; interest at 0%, through February 2023	-	126,296
Note payable to Bank of Texas (Equipment Note) dated September 9, 2018 for \$2,500,000; monthly payment of \$48,089 beginning October 9, 2018; interest at 5.71%, through September 2023	-	559,961
Note payable to Frost Bank (Refinance Commerce Note) dated April 3, 2020 for \$4,503,307; monthly payment of \$30,638 beginning May 3, 2020; interest at 2.70%, through April 3030. (Two Bell 407 helicopters)	3,633,697	3,696,771
Total	16,958,824	19,331,946
Less: discount on Zoll financing	-	(1,388)
Total debt	16,958,824	19,330,588
Current portion	1,731,619	2,371,458
Long-term debt	\$ 15,227,205	\$ 16,959,130

The Bank of Texas and Commerce Bank notes are governed by Promissory Notes and Business Loan Agreements for a security interest in ambulances, medical equipment, and helicopters and are subject to a fixed-charge-coverage-ratio financial covenant quarterly. For the quarters ended March 31, 2023 and June 30, 2023, and for the quarter and fiscal year ended September 30, 2023, the Company was not in compliance with its debt covenant requirements. The Company did obtain waivers from Bank of Texas and Commerce Bank for all the periods that the Company was not in compliance.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

The following is a summary of the future maturities of long-term debt for the years ending September 30:

2024	\$ 1,731,618
2025	1,778,976
2026	4,194,012
2027	1,351,736
2028	1,830,824
Thereafter	6,071,658
	<u>\$ 16,958,824</u>

Effective June 12, 2020, the Company increased the line of credit with Bank of Texas from \$2,000,000 to \$2,500,000. The term is for one year with the intent to renew each year in June. The loan can be used for working capital and general corporate purposes. The interest rate is variable with a current index of 4%. There was no balance due at September 30, 2023. The Company has long-term financing arrangements, with 0% interest, with Zoll Medical Corp. and Zoll Data Solutions. Per the nature of the financings, the Company imputed interest based on the most recent financing the Company had entered into with a bank, 4.2%. The Company had discounts recorded of \$0 and \$1,358 for the years ended September 30, 2023 and 2022, respectively.

NOTE E - ACCRUED LIABILITIES

Accrued liabilities consist of the following at September 30:

	2023	2022
Interest payable	\$ 31,079	\$ 23,730
Accrued payables	1,379,464	1,032,642
Payroll and benefits	4,446,279	4,505,914
Total accrued liabilities	<u>\$ 5,846,822</u>	<u>\$ 5,562,286</u>

NOTE F - RETIREMENT PLAN

The Company sponsors the CareFlite 401(k) Plan (the "Plan") covering all employees. Employees are eligible to participate in the Plan immediately upon hire; however, they do not receive an employer match until they have worked one full year with the Company. Employee contributions to the Plan are 100% vested and cannot exceed the maximum allowable deductions permitted under Section 401 of the IRC. The Company will match up to 125% of the employee's contributions up to a maximum employer contribution of 6% of the employee's salary. Company contributions vest based on the number of years of service. Total contributions made by the Company to the Plan during the years ended September 30, 2023 and 2022 were \$1,710,046 and \$1,672,617, respectively.

NOTE G - FUNCTIONAL EXPENSES

The Company provides medical transportation services to residents within its geographic area. General and administrative expenses for each program include onboarding costs, uniforms, certifications, training/licenses, various office supplies, travel/meeting expenses, printing, postage, telephone/internet, utilities, janitorial services, building repairs, building supplies, employee awards/gifts, and safety expenses. Certain expenses for the Fixed Wing program and Helicopter program are allocated based on patient

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

revenue percentage. The majority of the expenses are directly accounted for in each individual program. Expenses related to providing these services are as follows for the year ended September 30, 2023:

	Fixed Wing	Helicopter Operations	Ground Operations	Operation Center	General and Administrative	Total Expenses
Salaries and benefits	\$ 304,080	\$ 13,623,344	\$ 31,849,538	\$ 3,186,033	\$ 4,719,216	\$ 53,825,210
General and administrative	49,468	782,886	1,232,464	544,435	1,385,389	2,404,624
Billing fee	27,153	1,221,880	1,364,114			2,632,229
Operating	88,745	633,499	1,419,635	38,181	22,949	2,138,988
Fuel	770,002	954,466	1,814,305	35	18,291	2,737,031
Marketing and advertising	200	24,316	73,183	1,647	417,146	514,076
Insurance	85,411	1,783,507	1,354,288	70,144	1,284,744	4,466,714
Purchased services	10,782	450,265	830,523	196,512	1,848,369	3,247,463
Maintenance	785,746	3,663,447	1,116,070	6,984	14,063	5,166,910
Amortization and depreciation	77,818	941,559	1,164,235	368,397	1,021,422	3,672,946
	\$ 1,129,142	\$ 24,158,094	\$ 42,727,283	\$ 4,901,388	\$ 10,964,621	\$ 82,912,346

Expenses related to providing medical transportation services are as follows for the year ended September 30, 2022:

	Fixed Wing	Helicopter Operations	Ground Operations	Operation Center	General and Administrative	Total Expenses
Salaries and benefits	\$ 853,117	\$ 12,278,846	\$ 30,709,704	\$ 2,716,367	\$ 3,821,816	\$ 50,169,850
General and administrative	25,029	554,430	1,987,775	290,102	1,134,988	3,422,108
Billing fee	38,845	1,122,285	1,252,051			2,646,131
Operating	110,876	446,392	1,433,175	50,827	14,893	2,096,222
Fuel	198,098	1,041,195	1,245,850		37,493	3,222,337
Marketing and advertising	70	27,463	40,489	965	411,405	536,344
Insurance	97,409	1,444,375	1,140,811	2,703	960,010	3,695,313
Purchased services	14,881	382,286	843,811	73,877	1,355,704	2,966,646
Maintenance	295,250	2,601,805	1,080,349	795	26,320	4,907,334
Amortization and depreciation	64,972	659,136	1,062,815	427,044	1,146,290	3,360,257
	\$ 1,483,515	\$ 21,798,951	\$ 42,077,489	\$ 3,562,981	\$ 9,844,704	\$ 78,567,539

NOTE H - RELATED PARTIES

Included in patient accounts receivable at September 30, 2023 and 2022 is \$2,141,584 and \$1,456,868, respectively, due from the Company's Members relating primarily to patient billing, which will be reimbursed to the Company directly from the Members.

NOTE I - COMMITMENTS AND CONTINGENCIES

The Company purchases professional and general liability insurance to cover medical malpractice claims. There are no known incidents that may result in the assertion of additional claims. Management is not aware of any claims or contingencies that would be material to the financial position or results of operations of the Company.

The healthcare industry is subject to numerous laws and regulations of Federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulation by healthcare providers. Violations of these laws and regulations could result in expulsion from

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Company is in compliance with antifraud and abuse statutes as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

On November 1, 2008, the Company entered into an agreement with the Ellis County Emergency Services District No. 5 ("ESD 5") to be the primary ambulance provider for 911 services within the district. ESD 5 includes the City of Ferris, which provides a subsidy of \$36,000 per year. The agreement was renewed in October 2013 and October 2018 for another five years at \$36,000 per year. The contract was not renewed by the Company upon the end of the term.

On October 1, 2009, the Company entered into an agreement with Hill County Emergency Services District No. 2 ("ESD 2") to be the primary commercial ambulance provider for 911 services within the ESD 2. The term of the agreement is for five years and includes a \$600,000 per year cost sharing subsidy. Amendment 8 extended the term of the contract to September 30, 2027 with \$730,462 for October 2019 through September 2020. Each subsequent year will have an increase of 2% over the previous fiscal year or an increase of 2% plus the inflation rate in the previous fiscal year if inflation is 4% or greater.

On October 1, 2009, the Company entered into an agreement with the City of Baich Springs to be the primary commercial ambulance provider for 911 services within the city. On October 1, 2018, the agreement was amended and the services renewed until September 30, 2022 at \$150,000 per year. On October 1, 2021, the agreement was amended and the services renewed until September 30, 2023 at \$225,000 from October 1, 2021 through September 30, 2022 and \$300,000 from October 1, 2022 through September 30, 2023. The contract was not renewed by the Company upon the end of the term.

NOTE J - LEASES

The balances for the operating and finance leases where the Company is the lessee are presented as follows within the statements of financial position as of September 30, 2023:

	<u>2023</u>
Operating leases:	
Operating lease right of use assets	\$ 2,539,772
Current right of use liability	\$ 428,855
Long-term right of use liability	2,124,438
Total operating lease liabilities	<u>\$ 2,553,293</u>
Finance leases:	
Property and equipment, net	\$ 2,427,760
Current right of use liability	\$ 491,845
Long-term right of use liability	1,879,264
Total finance lease liabilities	<u>\$ 2,371,209</u>

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

The components of lease expense are as follows within the Company's statement of operations and changes in net assets for the year ended September 30, 2023:

	2023
Operating lease expense:	
Operating lease expense ⁽¹⁾	\$ 637,975
Finance lease expense:	
Depreciation of leased assets	251,534
Interest on lease liabilities	100,582
Total finance lease expense	352,116
Total lease expense	\$ 990,091

⁽¹⁾ Includes short-term leases and variable lease costs, which are immaterial.

The lease costs are reflected on the statement of operations and changes in net assets in the following expense line items:

	2023
Helicopter operations	\$ 85,340
Ground operations	807,601
Operations center	25,052
General and administrative	72,098
Total lease expense	\$ 990,091

Supplemental cash flow information related to leases was as follows during 2023:

	2023
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash outflows from operating leases	\$ 548,266
Operating cash outflows from finance leases (interest payments)	100,582
Financing cash outflows from finance leases	308,083
Supplemental disclosure of noncash leasing activities:	
Leased assets obtained in exchange for finance lease liabilities	2,679,292
Leased assets obtained in exchange for operating lease liabilities	870,177

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

The following table represents the weighted-average remaining lease term and discount rate as of September 30, 2023:

	2023
Weighted average remaining lease term (years):	
Operating leases	20.13
Finance leases	4.26
Weighted average discount rate:	
Operating leases	4.03%
Finance leases	6.20%

Future undiscounted lease payments for the Company's operating and finance lease liabilities are as follows as of September 30, 2023:

	Operating	Finance
2024	\$ 521,148	\$ 622,398
2025	191,087	622,398
2026	190,746	622,398
2027	174,678	622,398
2028	132,190	207,467
Thereafter	2,534,443	-
Total future lease payments	3,744,292	2,697,059
Less: imputed interest	(1,190,999)	(325,850)
Present value of lease liabilities	2,553,293	2,371,209
Less: lease liabilities, current	428,855	491,945
Lease liabilities, non-current	\$ 2,124,438	\$ 1,879,264

NOTE K - CAPITAL CONTRIBUTIONS

Periodically during the year, the Company receives unrestricted contributions. These amounts for the years ended September 30, 2023 and 2022 were approximately \$32,000 and \$36,000, respectively.

CareFlite

NOTES TO FINANCIAL STATEMENTS - CONTINUED

September 30, 2023 and 2022

NOTE L - LIQUIDITY AND AVAILABILITY OF RESOURCES

The following table reflects the Company's financial assets as of September 30, 2023 and 2022, that are available for general expenditure within one year. Financial assets are considered unavailable when illiquid or not convertible to cash within one year or are restricted funds.

	2023	2022
Financial assets:		
Cash and cash equivalents	\$ 11,152,944	\$ 21,080,462
Short Term Investments	18,152,700	15,685,330
Patient accounts receivable, net, due within one year	17,608,562	20,025,318
Accounts receivable - non-patient	284,146	266,027
	<u>47,188,352</u>	<u>57,057,135</u>
Financial assets available to meet cash needs for general expenditure within one year	\$ 47,188,352	\$ 57,057,135

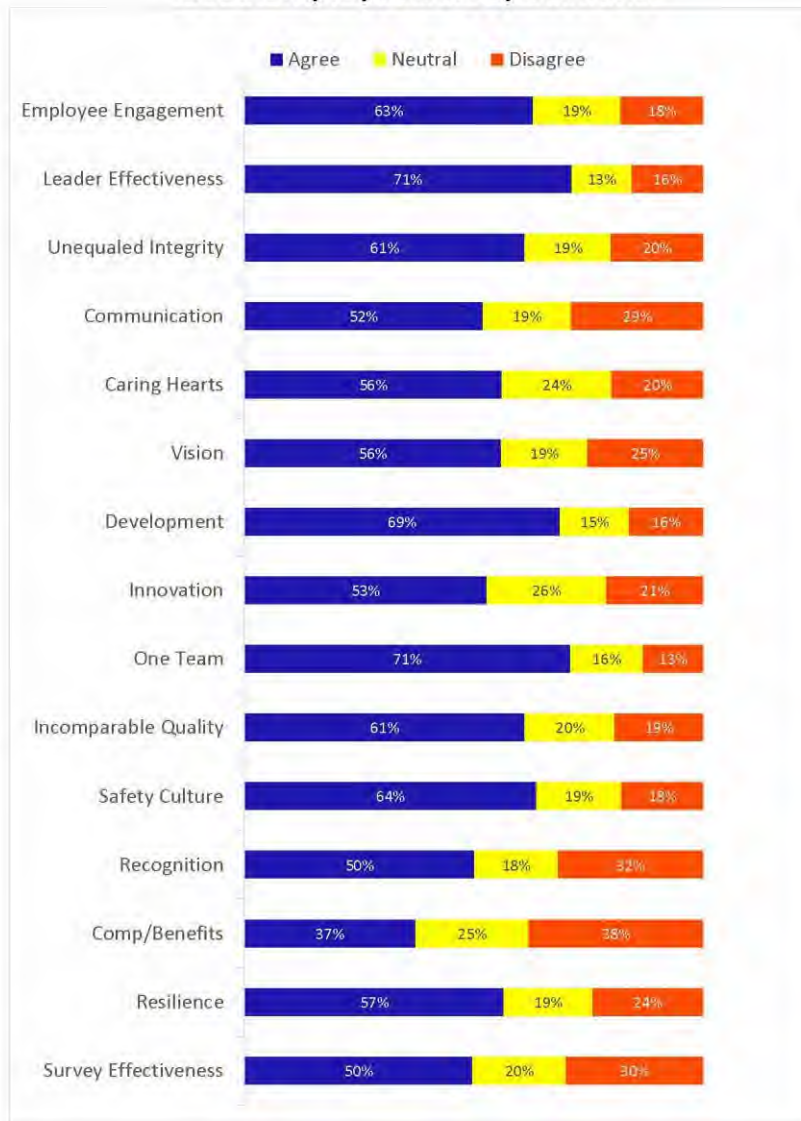
The Company also has an unsecured \$2,500,000 line of credit, which it could draw upon in the event of an anticipated liquidity need

NOTE M - SUBSEQUENT EVENTS

The Company has evaluated subsequent events through December 13, 2023, the date the financial statements were available to be issued, and has determined there are no additional material subsequent events or transactions that would require additional disclosure in the Company's financial statements.

5. Employee Survey

CareFlite 2023 Employee Survey Sections



6. ACE Accreditation

ACE CAREFLITE

ACCREDITATION PERIOD
2024-2027

The International Academy of Emergency Medical Dispatch officially recognizes CAREFLITE as an **ACCREDITED CENTER OF EXCELLENCE IN EMERGENCY MEDICAL DISPATCH** for demonstrating compliance to the highest level of standards as set forth in the Academy's Twenty Points of Accreditation. This accreditation is granted as of May 16th, 2024 and is valid until September 7th, 2027.

#130

RE-ACCREDITED CENTER OF EXCELLENCE

TWENTY POINTS OF ACCREDITATION

1. All medical dispatch calltaking, dispatching, and supervisory workstations.
2. Current Advanced Medical Priority Dispatch System (AMPDS) licensing of each EMD position.
3. Current Academy certification of all EMD personnel.
4. How Academy verification and case review will continue to be maintained.
5. Activity of Quality Improvement (QI) committee processes.
6. EMD quality assurance and improvement methodology.
7. Case review at the Academy's discretion and number and percentage of randomly reviewed cases.
8. EMD quality assurance and improvement database.
9. Current AMPDS case review (calendar) if monthly average case evaluation meets/does not meet accreditation standards:
 - 100%-Optimal Compliance
 - 75%-Low Compliance
 - 75%-Non-Complete
 - Percentage of deviation accepted:
 - 24%-Optimal Deviation
 - 24%-Match Deviation
 - 36%-Moderate Deviation
 - 36%-Minor Deviation
10. Correct case review and QI procedures initiated through independent Academy review.
11. How EMS field personnel were oriented to the proper use of the AMPDS and feedback report.
12. Local policies and procedures for implementation and maintenance of EMD.
13. Current Continuing Dispatch Education (CDE) and EMD recertification program functions.
14. How police and the dispatchers work oriented to the proper use of the SEND Protocol.
15. Properly established local configuration of all AMPDS response assignments.
16. How AMPDS response assignments will be regularly reviewed and recommended changes approved.
17. Incidence of all AMPDS codes and levels.
18. Specific Medical Director oversight and involvement in EMD activities.
19. Sharing of nonconfidential data with the Academy.
20. Support of the Academy's Code of Ethics, Code of Conduct, and practice standards.

IAED International Academy of Emergency Dispatch

ACE ACCREDITED CENTER OF EXCELLENCE

7. Ground CQI Process -10.1.5

CareFlite

POLICY NAME: Ground CQI Process

POLICY NUMBER: 10.1.5

VP APPROVAL: 

DATE: 1/22/16

CEO APPROVAL: 

DATE: 1/23/16

Date Implemented	Date Last Reviewed	Date Last Revised
01/2016		

CORE VALUE(s)

Safety, Quality, Customer Service, Fiscal Responsibility, Teamwork, Urgency

PURPOSE

The purpose of this policy is to put into place the actions to be taken to ensure that CareFlite's value of Quality is consistently improved by a comprehensive system of data analysis to identify trends and specific outliers. The analysis will be used to implement the appropriate training to be provided in a timely manner and/or to consider changes to CareFlite's medical protocols in order to constantly improve the quality of CareFlite's clinical care.

Ground CQI Flow Chart



Audit Percentages:

- Pre-Bill 100%
- 911 100%
- Critical Care 100%
- Non-emergent system, ALS 100%
- Non-emergent system, BLS 10%

Date Implemented: 1/2016

Revision Dates:

Page 1 of 3

POLICY NAME: Ground CQI Process**POLICY NUMBER: 10.1.5****Audit Time Standards:****Pre-Bill Audit:**

80% initial review completed during the shift. Remainder completed within 1 calendar day of end of shift. Charts returned to crew returned to Pre-Bill Auditor prior to the end of the shift (for 80% same shift, if returned to crew after shift ends, then returned to Pre-Bill Auditor prior to the end of the crew's next shift)

Clinical Audit:

100% initial review within 1 calendar day of PCR release from Pre-Bill Audit

Reporting Requirements:**Pre-Bill Audit:**

Report daily (7 days / week) the total number of PCR's released for Clinical Audit, total number of PCR's sent back to crew for additional information

Report monthly by 5th of next month the number and percentage of PCR's sent back to crews for additional information

Clinical Audit:

Report daily the total number & percent of PCR's released the prior calendar day that have been clinically reviewed

Report monthly by 5th of next month, the number and percentage of PCR's that were routed to each of the five categories above, major trends that are problematic and all run numbers that required a discussion with the crew or an immediate intervention (i.e. the PCR's that must be presented to CQI at the next meeting)

The Director of Ground Quality and Training shall maintain a status board, updated daily, which contains the following information:


- 1) The total number of PCR's released each calendar day by the Pre-Bill Audit team and the number of PCR's sent back to a crew member for any additional information
- 2) The total number of clinical audits completed for the PCR's released by the Pre-Bill Audit team on the prior calendar day.
- 3) A list of those employees who are responsible for completing the Pre-Bill and Clinical Audits.

POLICY NAME: Ground CQI Process

POLICY NUMBER: 10.1.5

- 4) A copy of the prior month's results in dashboard form
- 5) A copy of this policy

8. Quality Management Improvement Plan 10.1.2



POLICY- 10.01.02 – Quality Management Improvement Plan

Date Implemented	Date Last Reviewed	Date Last Revised
02/1998	01/2024	01/2024

CAREFIVE VALUES
 One Team, Incomparable Quality, Safety Culture, Unequaled Integrity, Caring Heart

PURPOSE
 To ensure quality care is delivered across all divisions of CareFlite.

POLICY

1. All Quality Management/Improvement projects should include the following steps and be documented as follows:
 - a. **Problem Statement** – Identify outstanding issues by:
 - i. Clearly defining the nature of the problem.
 - ii. Articulate/refine the scope of the problem as much as possible.
 - iii. Validate the extent of the situation/problem through data collection.
 1. For documentation purposes, the data may be presented in a graph, chart, or table format.
 2. Methodology for the data collection should also be documented.
 3. A flow chart may also be very helpful in identifying key points in the process which are problematic, especially when looking at a time related or complex process.
 - iv. Consider problem statements from both internal and external+ Quality Committees, Safety Committee, and Clinical Quality and Education Department.
 - v. Obtain consensus from the work group on the issues identified. Use the brainstorming process and examine all factors which could be causing and/or impacting the issue.
 - b. **Resolution/Plan** Through the group process, one or more options for improving the current situation should be suggested.
 - i. All options should be readily considered, evaluated and/or accepted.
 - ii. If necessary, use an evaluation grid (maximization matrix).
 - iii. Consider the cost/benefit analysis.
 - iv. Include time targets for implementation and evaluation.
 - v. Propose the best possible solution(s) for further study and review.
 - c. **Feasibility Review** For each potential solution, determine the following:
 - i. Economic analysis of similar solutions implemented locally, regionally, or at the national level.
 - ii. Assessment of projected costs associated with the solution(s).

References: OAMTS 12th Edition
 Date Implemented: 02/1998
 Revision Dates: 01/2011, 11/2011, 01/2015, 05/2017, 01/2024
 Page 1 of 2

POLICY: 10.01.02 – Quality Management / Improvement Plan

- iii. Estimated cost projection related to each solution.
 - iv. Maximum revenue realization regarding any given resolution.
 - d. **Establish Indicators:** When regarding outcome measurements with each potential solution(s):
 - i. Is the progress measurable?
 - ii. Are the success/failure indicators realistic, reliable, and repeatable?
 - iii. Are goals clearly stated and defined?
 - e. **Presentation/Proposal:** After above indicators are established, the proposed solution(s) should be prepared for presentation to the Quality Management Committee to best facilitate discussion, approval, and possible implementation plans.
 - f. **Approval/Implementation:** Approval by the majority of committee members is desirable. Subsequent implementation timeline established according to indicators.
 - g. **Evaluation:** Evaluate the implementation process according to indicated timelines.
 - i. Review the threshold outcomes throughout the progress of the plan.
 - ii. Consider various data collection methods to verify your results.
 - iii. Based on the data collected in the evaluation phase, it may be necessary to return to other causes for the problem and select other solution options for implementation.
2. Successful completion of the above steps is rarely the end of the project. Remember the goal is continuous improvement, and that requires repeated monitoring, change and assessment.

9. Open Door Policy Compliant Resolution HB17



POLICY: HB17 - Open Door Policy / Innovative Ideas and Interactive Resolutions

Date Implemented	Date Last Reviewed	Date Last Revised
2004	08/2023	08/2023

CAREFIVE VALUES

One Team, Incomparable Quality, Safety Culture, Unequaled Integrity, Caring Hearts

POLICY

CareFlite believes open communication within an atmosphere of mutual trust is of prime importance for its team members. CareFlite has established an “open door” policy for all team members to utilize in order to discuss innovative ideas and solutions as well as voice individual and collective concerns.

This policy is intended to encourage team members to think of new and exciting ideas for team members and CareFlite, as well as to establish an informal resolution process for team member’s issues and concerns. This “open door” policy is not a substitute for CareFlite’s Preventing Harassment Policy (HB10) or any other policy concerning conduct or interactions at issue.

Innovative Ideas

CareFlite seeks to foster an environment where team members can bring innovative ideas and solutions to the attention of CareFlite’s leadership. Any team member who has an idea related to their employment role, training, creative solutions to team member concerns, or CareFlite as a whole is encouraged to reach out to their immediate supervisor or other CareFlite leaders to pitch their ideas and/or solutions.

Interactive Resolutions

CareFlite values team member’s constructive opinions, suggestions, and feedback so that issues of concern can be effectively resolved in the workplace. If at any time you feel that a procedure, rule, or condition of employment has been administered in an unfair, unjust, or inequitable manner or you otherwise have any concern about unfair or prohibited treatment or conduct by anyone within the organization, or by any of our vendors, visitors, clients, or customers, you should follow the procedure described herein for bringing your concern to management’s attention.

CareFlite’s “open door” policy means that the door to a team member’s supervisor is always open and team members are encouraged to and should feel comfortable speaking with their

0612919-7
References: HB3, HB10, 1.1.4
Date Implemented: 01/2007
Revision Dates: 8/2010, 09/2012, 07/2013, 09/2014, 12/2016, 04/2021, 02/2023, 08/2023
Page 1 of 2



CareFlite

POLICY: HB17 - Open Door Policy / Innovating Ideas and Interactive Resolutions

supervisor concerning any questions and/or concerns they have. In deciding to escalate a problem or complaint to the leadership team, the team member should follow their proper chain of command (i.e. Supervisor, Manager, Director, Vice President, CEO). If anyone in the direct chain of command is the subject or a source of the complaint or concern, or the resolution was not addressed with a supervisor, the team members may escalate the matter within the chain of command. CareFlite leadership should seek to resolve the team member's concern, answer any questions, and treat a team member's concerns with confidentiality to the extent such issues can remain confidential. Human Resources and/or the Compliance Officer must be involved in any matters within their purview.

Some complaints or problems may warrant going directly to Human Resources (e.g. harassment) or the Compliance Officer (e.g. billing fraud) or through CareFlite's Employee Helpline (800-461-9330) or Employee Helpline and Reporting System [website](#). Concerns can be anonymously made through the helpline and website. A team member should feel free to report these incidents without fear of retaliation.

RESOLUTION PROCEDURES

Any team member who believes they have been subjected to conduct they believe violates the Preventing Harassment Policy (HB10) must follow the complaint procedure described in that policy.

For issues and concerns that fall under this Open Door policy, team members should comply with the following steps.

Step One. Discussion of the problem with your immediate supervisor is encouraged as a first step. If, however, you do not believe a discussion with your supervisor is appropriate, you may proceed directly to Step Two.

Step Two. If your problem is not resolved after discussion with your supervisor or if you feel the discussion with your supervisor is not the appropriate next step, you may escalate the matter to the next leader in the chain of command. If deemed appropriate or in light of the concern, you are encouraged to contact Human Resources, the Compliance Officer, or the Employee Helpline (800-461-9330) or via the Employee Helpline [website](#).

It is a violation of CareFlite's policy to retaliate against anyone who brings a good-faith concern to CareFlite leadership's attention in connection with this policy. CareFlite does not tolerate any form of retaliation against any team member availing themselves of this procedure. Any form of retaliation will be investigated by the Human Resources Department (additionally CareFlite's Legal Counsel may be consulted) and an individual found to have retaliated against a team member will be subject to disciplinary action, up to and including termination.

10. Customer Relations-Complaint Resolution 1.1.17



POLICY: 01.01.17 - Customer Relations & Complaint Resolution

Date Implemented	Date Last Reviewed	Date Last Revised
12/2008	12/2023	12/2023

CAREFIVE VALUES

One Team, Incomparable Quality, Safety Culture, Unequaled Integrity, Caring Hearts

PURPOSE

To define the expectations of CareFlite team members regarding customer service and the process for resolving and tracking customer complaints.

POLICY

CareFlite strives to consistently provide patients with quality care and exceptional service. To fulfill our commitment to excellent customer service, we expect the following from each of our team members:

- Provide courteous service in a prompt and efficient manner;
- Establish and maintain positive relationships with clients by gaining their trust and respect through professional, honest interaction;
- Handle complaints quickly and professionally. Never argue with a client. If you are unable to resolve the complaint to the client's satisfaction, review the situation with your supervisor;
- Communicate with patients and other outside clients such as physicians or vendors in a professional manner, whether in person, over the phone, or via e-mail;
- Always remember that you are CareFlite to our patients and other external customers.

It is the policy of CareFlite to handle customer complaints as quickly as possible at the lowest level possible within the organization. All customer complaints will be addressed within one (1) business day and resolved as soon as possible.

PROCEDURE

- I. Any staff member receiving a customer complaint should attempt to resolve it immediately. If the staff member is unable to resolve the complaint, because they feel it is not within their authority to do so, it should be referred to their supervisor immediately. If the supervisor is unable to resolve the complaint immediately, the

001914-3
References: Policy 10.01.03 Sentinel Events;
Date Implemented: 12/2008
Revision Dates: 11/2011, 12/2014, 02/2017, 08/2018, 08/2020, 05/2021, 12/2023
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CareFlite

POLICY: 01.01.17 - Customer Relations & Complaint Resolution

complaint should be referred to the appropriate Manager, Director, and Vice President, in succession, until complete.

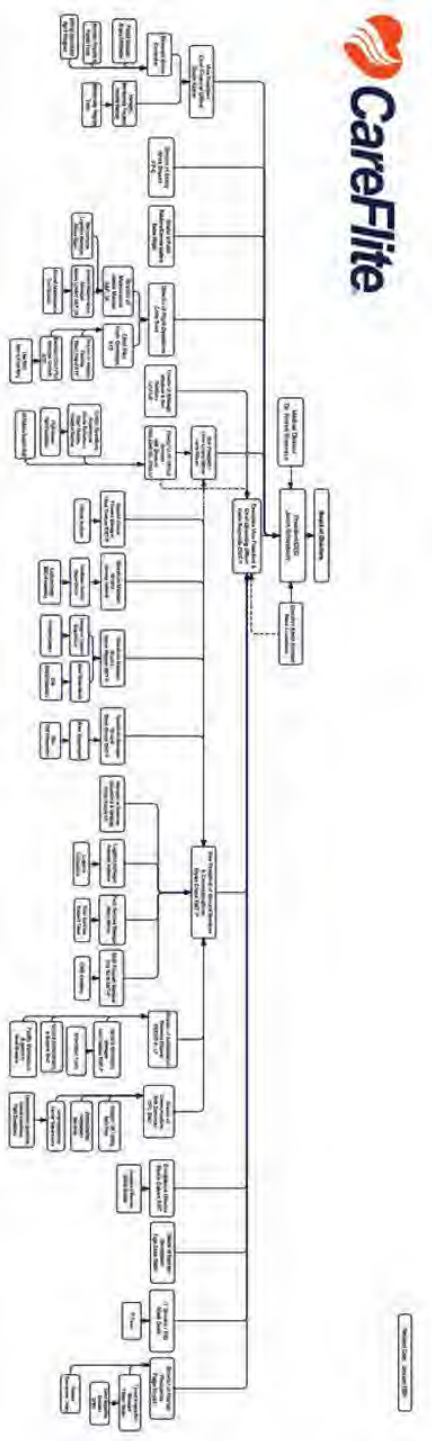
2. Complaints received by or referred to a Director or Vice President should be followed up on as soon as practicable. Complaints requiring additional investigation will have a timeline communicated to the customer for follow-up and resolution.
3. If a complaint cannot be resolved quickly, requires legal advice, or has legal implications, it will be referred to the President/CEO for review and legal counsel may be consulted.
4. All clinical complaints or complaints regarding the care and/or treatment of a patient will be referred to either the Director of Air Clinical Services for air or the VP of Ground Operations for ground. Those individuals may involve other resources and departments for investigation and resolution.
5. Any complaint involving the safety of a patient, customer, or the public will be referred to both the Director of Air Clinical Services or Director of Operations for air or the VP of Ground Operations for ground. Those individuals are expected to collaborate with the Director of Safety who may involve other resources and departments for investigation and resolution.
6. Complaints that fall under the category of "Sentinel Events" should be immediately referred to the Director of Air Clinical Services for air or the VP of Ground Operations for ground. *See Policy 10.01.03 Sentinel Events.*
7. Complaints of any nature will be resolved in a professional manner.
8. If the complaint is not resolved and escalates to a formal grievance, legal counsel will be contacted. All team members will be required to cooperate with legal counsel during any grievance resolution process.

12. Fee Schedule

Code	Category	Cost
A0425	ALS Mileage	40.00
A0427	ALS-1 Emergency	2,100.00
A0426	ALS-1, non-Emergency	1,600.00
A0433	ALS-2	3,100.00
A0425	BLS Mileage	40.00
A0429	BLS Emergency	1,600.00
A0428	BLS, Non-Emergency	1,100.00
A0425	Critical Care Ground Mileage	85.00
A0434	Critical Care Ground	9,000.00

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13. Organization Chart



14. Outstanding/Pending Litigation

CareFlite Legal Matters (2019-2024)

Medical Air Services Association, Inc. v. CareFlite	Dismissed with prejudice
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Federal:

State of Texas:

CareFlite v. New Lifecare Hospitals of North Texas	Stayed for Defendant’s Bankruptcy
CareFlite v. Camelot Sports & Entertainment, LLC	Case Closed
CareFlite v. Country View Nursing and Rehabilitation	Release and Satisfaction of Judgement
CareFlite v. Gruenepointe 1 Kaufman, LLC	Default Judgement Granted
CareFlite v. Gruenepointe 1 Kemp, LLC	Default Judgement Granted
CareFlite v. Texas Workforce Commission, et al	Case Closed
Christi L. Fischer v. Rodney D. Hall, et al	Case Closed
T.S., et al v. CareFlite	Case Closed
Salvador Saldivar v. Henry Johnson, et al	Nonsuit with Prejudice
CareFlite v. Onpointe Management, LLC et al	Nonsuit with Prejudice
Willie G. Taylor, Jr. et al v. CareFlite, et al	Case Closed
CareFlite v. Navarro Hospital LP	Nonsuit with Prejudice
Willie G. Taylor, et al v. CareFlite, et al	Case Closed
James Swartz v. The CareFlite	Active
Matthew Sarchi v. CareFlite Ground Ambulance-East, Inc., et al	Case Closed
Peggy J. Flowers v. CareFlite, et al	Nonsuit Without Prejudice
Juan Hector Moreno, Jr. v. CareFlite, et al	Active- Jury Trial Set 8/24

VI. Price Proposal

VII. Required Forms

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