# Sacramento County EMS Agency
## Stroke Center
## Application Packet

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**Sacramento County EMS Agency Stroke Center**
**Application for Designation Instructions**

Thank you for your interest in applying for stroke center designation in Sacramento County. Carefully review the application instructions prior to submitting your application packet.

As part of the California Stroke Critical Care System, Sacramento County EMS Agency (SCEMSA) offers an application process for hospitals wishing to identify as a stroke receiving center. Hospitals designated as a stroke receiving center are certified as a primary stroke center by The Joint Commission (TJC) and approved by SCEMSA to manage patients from Sacramento County with symptoms of Stroke Disease. SCEMSA has developed stroke policies to appropriately identify, triage and transport patients suffering from a potential stroke to a stroke receiving center.

The process to apply for Stroke Center (stroke-receiving center) Designation in Sacramento County includes:

Step 1:

- ❖ Completion of the Stroke Center Designation Application (attached)
- ❖ Documentation of Primary Stroke Center certification by The Joint Commission

Step 2. Once SCEMSA receives and reviews the application the following will be sent to the appropriate personnel for review and signatures:

- ❖ Agreement to abide by the Sacramento County Stroke Designation Policy
- ❖ Documentation of all items listed as required in the Stroke Designation Policy
- ❖ Signed contracts that define roles and responsibilities of stakeholders, confidentiality, data access and management as well as the CQI processes
- ❖ Informational site visits by EMS Agency staff
- ❖ Fees are annual per designated stroke center for supporting stroke system oversight, data management, and community educational efforts. Fees will be collected by Sacramento County EMS with the first installment due with signed contract.

A completed application including all supporting documents can be submitted via mail to:

Sacramento County EMS Agency
9616 Micron Ave, Suite 960
Sacramento, California 95827
916.875.9753
Or can be emailed to: SCEMSAINFO@saccounty.net

**SACRAMENTO COUNTY**
**Department of Health Services**
**Emergency Medical Services Agency**
**9616 Micron Avenue, Suite 960**
**Sacramento CA 95827**
**Counter Hours:**
**Tuesday-Thursday 8:00-12:00**
**Tel: (916) 875-9753**
**Fax: (916) 854-9211**

# STROKE CENTER DESIGNATION APPLICATION

Please check one:

☐ PSC Initial Designation $*13,000*
☐ PSC Re-Designation $*13,000*
☐ CSC Initial Designation $*18,500*
☐ CSC Re-Designation $*18,500*
☐ TC Initial Designation $*6,500*
☐ TC Re-Designation $*6,500*

*Application processing requires a minimum of **30 business days** once all materials are received. Complete application in ink.*

Hospital Name:

Physical Address:

City: | State: | Zip:

Mailing Address:

City: | State: | Zip:

Phone: | Completion Date:

Name and Credentials of Person Completing the Form:

Title: | Hospital Department:

E-mail: | Phone:

Facility Stroke Program Medical Director Name: | Phone:

Email:

Facility Stroke Program Coordinator Name: | Phone:

Email:

Is your facility currently a certified stroke center by The Joint Commission?:  ☐ Yes     ☐ No   Level of current certification:_____

- If yes, what was the most recent date of certification?_____
  - Please list the expected date of your next evaluation for re-certification by The Joint Commission:_____
- If no, are you in the process of applying or planning to apply for certification?   ☐ Yes     ☐ No
  - If yes, when do you anticipate certification completion?:_____

☐ EMS Site Visit to Stroke Center Applicant: | *Staff initials _____ Date of visit_____*
☐ Written Contract in place: | *Staff initials _____ Expiration _____*
☐ Annual Designation Fee | *Staff initials _____*

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**Department of Health Services**

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TC Re-Designation $ *6,500*

*Application processing requires a minimum of **30 business days** once all materials are received. Complete application in ink.*

Hospital Name:

Physical Address:

City: | State: | Zip:

Mailing Address:

City: | State: | Zip:

Phone: | Completion Date:

Name and Credentials of Person Completing the Form:

Title: | Hospital Department:

E-mail: | Phone:

Facility Stroke Program Medical Director Name: | Phone:

Email:

Facility Stroke Program Coordinator Name: | Phone:

Email:

Is your facility currently a certified stroke center by The Joint Commission?: Yes No Level of current certification:_____

- If yes, what was the most recent date of certification?_____
  - Please list the expected date of your next evaluation for re-certification by The Joint Commission:_____
- If no, are you in the process of applying or planning to apply for certification? Yes No
  - If yes, when do you anticipate certification completion?:_____

EMS Site Visit to Stroke Center Applicant: *Staff initials _____ Date of visit_____*
Written Contract in place: *Staff initials _____ Expiration _____*
Annual Designation Fee $ *Staff initials _____*

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