

**IDAHO EMS BUREAU**  
**FY2010 EMS DEDICATED GRANT FUND APPLICATION**  
**Due May 31, 2009**

**EMS COMPLIANCE SPECIALIST REVIEW**

**Highly Recommended**

\_\_\_\_\_  
 EMS Compliance Specialist Signature

\_\_\_\_\_  
 Date

**Section A. Agency Information**

Pending EMS License Change:

Agency Name: \_\_\_\_\_ EMS License #: \_\_\_\_\_

2008 Call Volume: Requests for EMS service: \_\_\_\_\_ Number of patients transported: \_\_\_\_\_

*Estimated Population in your Primary Response Area:*

Residents \_\_\_\_\_ Migrants \_\_\_\_\_ Tourists \_\_\_\_\_

Primary Grant Contact: \_\_\_\_\_

Contact Information: Phone #: \_\_\_\_\_ Other/E-Mail: \_\_\_\_\_

Agency Federal Tax Identification Number: \_\_\_\_\_

**FISCAL INFORMATION**

***(NOT PROJECTED)***

**ONE FULL YEAR**

From: Month \_\_\_\_\_ Year \_\_\_\_\_ Through: Month \_\_\_\_\_ Year \_\_\_\_\_ *(No later than May 31, 2009)*

**INCOME**

**EXPENSES**

FUNDING SOURCE	REVENUE
Ambulance Taxing District	
Fire Taxing District	
Hospital Taxing District	
General Fund	
State Motor Vehicle Funds	
Grant Funds	
Billing for EMS Services	
Donations / In Kind Contrib.	
Cash on Hand	
Investment Income	
Other	
<b>TOTAL</b>	

CATEGORY	EXPENSES
Personnel	
Operating	
Capital	
Other	
<b>TOTAL</b>	

*If not billing for EMS services, explain why on Narrative Page(s) 7 - 9*

*Explanation(s) of funds designated for specific use :*

\_\_\_\_\_  
 \_\_\_\_\_

Financial Verification Contact: \_\_\_\_\_

Financial Contact Information: Phone #: \_\_\_\_\_ Other/E-Mail: \_\_\_\_\_

## Section B. Emergency Vehicle Application

Vehicle requested:

Make	Model	Purpose	Configuration	4x4 Y/N	Base Price Quote	\$ Request

Total number of licensed vehicles used for emergency medical services in agency fleet: \_\_\_\_\_

Similar vehicle(s) currently in use:

Make	Model	Purpose	Years of Use for this Purpose	Configuration	4x4 Y/N	Mileage	License #	VIN #

Vehicle(s) to be replaced: *(Refer to Instructions pages 10 – 11)*

**DO NOT COMPLETE THIS TABLE IF VEHICLE IS TO BE RETAINED FOR CURRENT PURPOSE:**

Condition	Age Yrs	License

4x4 Needed (% of calls in 2008):
<input type="checkbox"/> 0% - 20%
<input type="checkbox"/> 21% - 40%
<input type="checkbox"/> 41% - 60%
<input type="checkbox"/> 61% - 80%
<input type="checkbox"/> 81% - 100%

Electronic photos of vehicle(s) to be replaced *(3/4 view from back and 3/4 view from front)*  
Send to: [IdahoEMS.dhw.idaho.gov](http://IdahoEMS.dhw.idaho.gov) or mailed to the EMS Bureau along with completed application.

Copy of registration or title to vehicle being replaced.

County or City name to be on new vehicle title *(required)*: \_\_\_\_\_  
*(Must have endorsed application and have notation they are aware of title requirement.)*

Please list additional vehicle needs below. This request is for Bureau use to indicate agency needs statewide. It is **NOT** necessary to prioritize requests, obtain vendor price quotes, nor submit Narrative of Need. ***This listing is for information only.***

Vehicle Description	Purpose	Age of Oldest Similar Vehicle	Approximate Cost

## Section C. Equipment Application

**Equipment requested:** List each item as a separate priority on a separate line, except for items that come as a kit as listed on manufacturer's web site or catalog. Extrication kits sold as such may be listed as one priority.

*Snowmobiles, boats, ATVs, trailers, firefighting equipment, disposable items, and training equipment are not eligible for the dedicated grant program.*

Priority	Item Description		Purpose		\$ Request		
<b>1</b>							
	# Anticipated Use	Time per Use (in Minutes)	Vendor Base Price				
Similar Equipment Currently in Use	Description	Purpose	Distance	Time	Condition	Age-Yrs	Replace Y/N

Priority	Item Description		Purpose		\$ Request		
<b>2</b>							
	# Anticipated Use	Time per Use (in Minutes)	Vendor Base Price				
Similar Equipment Currently in Use	Description	Purpose	Distance	Time	Condition	Age-Yrs	Replace Y/N

Priority	Item Description		Purpose		\$ Request		
<b>3</b>							
	# Anticipated Use	Time per Use (in Minutes)	Vendor Base Price				
Similar Equipment Currently in Use	Description	Purpose	Distance	Time	Condition	Age-Yrs	Replace Y/N

**TOTAL AMOUNT OF EQUIPMENT REQUESTED \$ \_\_\_\_\_**

The Dedicated Grant program typically has adequate funds for agency’s first and, possibly, second priorities. Third priorities have been funded only rarely. If your agency has equipment needs other than those listed above, please list them below. This will give the Bureau a more complete listing of equipment needs throughout the state, even though it is not likely funding will be available. It is not necessary to prioritize requests, obtain vendor price quotes, nor submit “*Narrative of Need*”.

***This listing is for information only.***

Item Description	Purpose	Quantity Needed	Approximate Cost

## **SECTION D. EPIPEN® APPLICATION**

EpiPens® may be requested separate from equipment requests. BLS and ALS agencies must be approved to participate in the EpiPen® program by completing and returning the *Epinephrine Auto-Injector Program Licensure Agreement* to the EMS Bureau. Quantity is limited to two (2) adult and two (2) pediatric pens per agency vehicle as listed on Agency Database, plus one (1) each size for reserve. Award price cap will be set annually by EMSAC Grant Subcommittee based on reasonable cost by vendor.

Description	Quantity	# Agency Vehicles	Anticipated Use Times
EpiPens® - Adult			
EpiPens® - Pediatric			

# Section E. Vehicle Narrative Form

Agency # \_\_\_\_\_

2008 Call Volume \_\_\_\_\_

Agency submits all Patient Care Reports (PCR) or Prehospital Electronic Record Collection System (PERCS) as required by Idaho EMS Rule on timely basis: Yes \_\_\_\_\_ No \_\_\_\_\_

Explanation:

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Agency bills for EMS service: Yes \_\_\_\_\_ No \_\_\_\_\_

If No, explain: \_\_\_\_\_

## **PART 1 - JUSTIFICATION OF NEED**

Explain how receiving the requested item will improve patient care and/or benefit your agency and how this will be determined.

If Applicable:

- If requesting a vehicle that will be replaced by a currently owned vehicle, explain what the replacement plan is to be.
- Optional: If a professional has determined the vehicle or equipment is not repairable or should be replaced, attach that assessment.

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## **PART 2 – EXPLANATION FOR LACK OF AVAILABLE FUNDS**

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## Section F. Grant Application Checklist

**THE FOLLOWING ATTACHMENTS ARE REQUIRED FOR COMPLETION OF THE APPLICATION:**

ATTACHMENT NAME	(Place <input checked="" type="checkbox"/> for applicable entries)
Completed <i>Request for Taxpayer Identification Number and Certification</i> (W-9)	<input type="checkbox"/>
County and/or City endorsement(s) ( <i>one minimum</i> )	<input type="checkbox"/>
Vehicle vendor price quote for vehicle being requested	<input type="checkbox"/>
Electronic photos of vehicle(s) to be replaced ( <i>minimum of two views</i> ), if applicable	<input type="checkbox"/>
Copy of registration or title of vehicle(s) to be replaced, if applicable	<input type="checkbox"/>
Narrative of need for vehicle being requested to include agency billing and PCR submission information	<input type="checkbox"/>
Equipment vendor price quote(s) for each equipment item being requested	<input type="checkbox"/>
Narrative of need for each equipment item being requested to include agency billing and PCR submission information	<input type="checkbox"/>

**THE FOLLOWING INFORMATION IS REQUIRED FOR GRANT ELIGIBILITY:**

Call Volume for 2008
Estimated resident population in primary response area in Idaho
Estimated migrant population in primary response area in Idaho
Estimated tourist population in primary response area in Idaho
Financial information (most recently completed 12-month period)
Funding sources and revenue generated by source
Name of contact person for fiscal information
Age and condition of vehicle or equipment being replaced, if applicable
Prioritization of equipment needs ( <i>pre-numbered in table</i> )
Type, quantity, and purpose of similar vehicles and/or equipment presently in use by applicant
Information on agency submission of all Patient Care Reports "PCR" or Prehospital Electronic Record Collection System (PERCS) as required by Idaho EMS Rule

**APPLICATIONS ARE DUE ON OR BEFORE MAY 31, 2009**

Postmarked or Hand Delivered to EMS Bureau Central Office

Late applications shall be excluded from consideration for any award

**SEND TO:**

EMS BUREAU CENTRAL OFFICE, P O BOX 83720, BOISE ID 83720-0036

**OBTAIN A RECEIPT OF MAILING OR HAND DELIVER NO LATER THAN 5 PM TO:**

EMS BUREAU CENTRAL OFFICE

590 W WASHINGTON ST

BOISE, IDAHO 83702

**OBTAIN A RECEIPT ACKNOWLEDGEMENT**

**RETAIN RECEIPT UNTIL EMS BUREAU HAS CONFIRMED RECEIPT OF APPLICATION**

## Section G. Signature Page

### SIGNATURE

I hereby certify that the information contained in this application is true and correct, and if awarded, that all unused dedicated grant funds must be returned to the EMS Bureau by April 1, 2010.

Signature of person authorized to sign for agency: \_\_\_\_\_

Printed name and title: \_\_\_\_\_

Date: \_\_\_\_\_



IDAHO DEPARTMENT OF  
HEALTH & WELFARE