EMS MATCHING GRANT APPLICATION

FLORIDA DEPARTMENT OF HEALTH
Emergency Medical Services Program

Complete all items unless instructed differently within the application

Type of Grant Requested: ☐ Rural ☐ Matching

ID. Code (The State Bureau of EMS will assign the ID Code – leave this blank) _____

1. Organization Name:	
2. Grant Signer: (The applicant signatory who has authority to sign contracts, grants, and other legal documents. This individual must also sign this application) Name:	
Position Title:	
Address:	
City:	County:
State: Florida	Zip Code:
Telephone:	Fax Number:
E-Mail Address:	

3. Contact Person: (The individual with direct knowledge of the project on a day-to-day basis and responsibility for the implementation of the grant activities. This person may sign project reports and may request project changes. The signer and the contact person may be the same.) Name:	
Position Title:	
Address:	
City:	County:
State: Florida	Zip Code:
Telephone:	Fax Number:
E-Mail Address:	

4. Legal Status of Applicant Organization (Check only one response):
   (1) ☐ Private Not for Profit [Attach documentation-501 (3) ©]
   (2) ☐ Private For Profit
   (3) ☐ City/Municipality/Town/Village
   (4) ☐ County
   (5) ☐ State
   (6) ☐ Other (specify): _____

5. Federal Tax ID Number (Nine Digit Number). VF _ _ _ _ _ _ _ _ _

6. EMS License Number: _____ Type: ☐Transport ☐Non-transport ☐Both

7. Number of permitted vehicles by type: _____ BLS; _____ ALS Transport; _____ ALS non-transport.

8. Type of Service (check one): ☐ Rescue; ☐ Fire; ☐ Third Service (County or City Government, nonfire); ☐ Air ambulance; ☐ Fixed wing; ☐ Rotowing; ☐ Both; ☐Other (specify) _____.

9. Medical Director of licensed EMS provider: If this project is approved, I agree by signing below that I will affirm my authority and responsibility for the use of all medical equipment and/or the provision of all continuing EMS education in this project**. [No signature is needed if medical equipment and professional EMS education are not in this project.]**

Signature: _____ Date: _____

Print/Type: Name of Director _____

FL Med. Lic. No. _____

Note: All organizations that are not licensed EMS providers must obtain the signature of the medical director of the licensed EMS provider responsible for EMS services in their area of operation for projects that involve medical equipment and/or continuing EMS education.

If your activity is a research or evaluation project, omit Items 10, 11, 12, 13, and skip to Item Number 14. Otherwise, proceed to Item 10 and the following items.

10. Justification Summary: Provide on no more than three one sided, double spaced pages a summary addressing this project, covering each topic listed below.

A) Problem description (Provide a narrative of the problem or need);
B) Present situation (Describe how the situation is being handled now);
C) The proposed solution (Present your proposed solution);
D) Consequences if not funded (Explain what will happen if this project is not funded);
E) The geographic area to be addressed (Provide a narrative description of the geographic area);
F) The proposed time frames (Provide a list of the time frame(s) for completing this project);
G) Data Sources (Provide a complete description of data source(s) you cite);
H) Statement attesting that the proposal is not a duplication of a previous effort (State that this project doesn't duplicate what you've done on other grant projects under this grant program).

Next, only complete one of the following: Items 11, 12, or 13. Read all three and then select and complete the one that pertains the most to the preceding Justification Summary. Note that on all three, that before-after differences for emergency victim data are the highest scoring items on the Matching Grants Evaluation Worksheet used by reviewers to evaluate your application form.

11. Outcome For Projects That Provide or Effect Direct Services To Emergency Victims: This may include vehicles, medical and rescue equipment, communications, navigation, dispatch, and all other things that impact upon on-site treatment, rescue, and benefit of emergency victims at the emergency scene. Use no more than two additional one sided, double-spaced pages for your response. Include the following.

A) Quantify what the situation has been in the most recent 12 months for which you have data (include the dates). The strongest data will include numbers of deaths and injuries during this time.
B) In the 12 months after this project's resources are on-line, estimate what the numbers you provided under the preceding "(A)" should become.
C) Justify and explain how you derived the numbers in (A) and (B), above.
D) What other outcome of this project do you expect? Be quantitative and explain the derivation of your figures.
E) How does this integrate into your agency's five year plan?

12. Outcome For Training Projects: This includes training of all types for the public, first responders, law enforcement personnel, EMS and other healthcare staff. Use no more than two additional one sided, double-spaced pages for your response. Include the following:

A) How many people received the training this project proposes in the most recent 12 month time period for which you have data (include the dates).
B) How many people do you estimate will successfully complete this training in the 12 months after training begins?
C) If this training is designed to have an impact on injuries, deaths, or other emergency victim data, provide the impact data for the 12 months before the training and project what the data should be in the 12 months after the training.
D) Explain the derivation of all figures.
E) How does this integrate into your agency's five year plan?

13. Outcome For Other Projects: This includes quality assurance, management, administrative, and other. Provide numeric data in your responses, if possible, that bear directly upon the project and emergency victim deaths, injuries, and/or other data. Use no more than two additional one sided, double-spaced pages for your response. Include the following.

A) What has the situation been in the most recent 12 months for which you have data (include the dates)?
B) What will the situation be in the 12 months after the project services are on-line?
C) If this project is designed to have an impact on injuries, deaths, or other emergency victim data, provide the impact data for the 12 months before the project and what the data should be in the 12 months after the project.
D) Explain the derivation of all numbers.
E) How does this integrate into your agency's five year plan?

Skip Item 14 and go to Item 15, unless your project is research and evaluation and you have not completed the preceding Justification Summary and one outcome item.

14. Research and Evaluation Justification Summary, and Outcome: You may use no more than three additional one sided, double spaced pages for this item.

A) Justify the need for this project as it relates to EMS.
B) Identify (1) location and (2) population to which this research pertains.
C) Among population identified in 14(B) above, specify a past time frame, and provide the number of deaths, injuries, or other adverse conditions during this time that you estimate the practical application of this research will reduce (or positive effect that it will increase).
D) (1) Provide the expected numeric change when the anticipated findings of this project are placed into practical use.
(2) Explain the basis for your estimates.
E) State your hypothesis.
F) Provide the method and design for this project.
G) Attach any questionnaires or involved documents that will be used.
H) If human or other living subjects are involved in this research, provide documentation that you will comply with all applicable federal and state laws regarding research subjects.
I) Describe how you will collect and analyze the data.

ALL APPLICANTS MUST COMPLETE ITEM 15.

15. Statutory Considerations and Criteria: The following are based on s. 401.113(2)(b) and 401.117, F.S. Use no more than one additional double spaced page to complete this item. Write N/A for those things in this section that do not pertain to this project. Respond to all others.

Justify that this project will:
A) Serve the requirements of the population upon which it will impact.
B) Enable emergency vehicles and their staff to conform to state standards established by law or rule of the department.
C) Enable the vehicles of your organization to contain at least the minimum equipment and supplies as required by law, rule or regulation of the department.
D) Enable the vehicles of your organization to have, at a minimum, a direct communications linkup with the operating base and hospital designated as the primary receiving facility.
E) Enable your organization to improve or expand the provision of:
1) EMS services on a county, multi county, or area wide basis.
2) Single EMS provider or coordinated methods of delivering services.
3) Coordination of all EMS communication links, with police, fire, emergency vehicles, and other related services.

16. Work activities and time frames: Indicate the major activities for completing the project (use only the space provided). Be reasonable, most projects cannot be completed in less than six months and if it is a communications project, it will take about a year. Also, if you are purchasing certain makes of ambulances, it takes at least nine months for them to be delivered after the bid is let.

Work Activity	**Number of Months After Grant Starts** Begin End

17. County Governments: If this application is being submitted by a county agency, describe in the space below why this request cannot be paid for out of funds awarded under the state EMS county grant program. Include in the explanation why any unspent county grant funds, which are now in your county accounts, cannot be allocated in whole or part for the costs herein.

18. Budget:		
Salaries and Benefits: For each position title, provide the amount of salary per hour, FICA per hour, fringe benefits, and the total number of hours.	**Costs**	**Justification:** Provide a brief justification why each of the positions and the numbers of hours are necessary for this project.
TOTAL:	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total

Expenses: These are travel costs and the usual, ordinary, and incidental expenditures by an agency, such as, commodities and supplies of a consumable nature, excluding expenditures classified as operating capital outlay (see next category).	**Costs:** List the price and source(s) of the price identified.	**Justification:** Justify why each of the expense items and quantities are necessary to this project.
TOTAL:	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total

Vehicles, equipment, and other operating capital outlay means equipment, fixtures, and other tangible personal property of a non consumable and non expendable nature, and the normal expected life of which is 1 year or more.	**Costs:** List the price of the item and the source(s) used to identify the price.	**Justification:** State why each of the items and quantities listed is a necessary component of this project.
TOTAL:	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total

State Amount (Check applicable program) ☐ Matching: 75 Percent	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total
☐ Rural: 90 Percent	**$0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total
Local Match Amount (Check applicable program) ☐ Matching: 25 Percent	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total
☐ Rural: 10 Percent	**$ 0.00**	Right click on 0.00 then left click on "Update Field" to calculate Total
Grand Total	**$ 0.00**	Right click on 0.00 then left click on

19. Certification:
My signature below certifies the following:
I am aware that any omissions, falsifications, misstatements, or misrepresentations in this application may disqualify me for this grant and, if funded, may be grounds for termination at a later date. I understand that any information I give may be investigated as allowed by law. I certify that to the best of my knowledge and belief all of the statements contained herein and on any attachments are true, correct, complete, and made in good faith.
I agree that any and all information submitted in this application will become a public document pursuant to Section 119.07, Florida Statutes (F.S.), when received by the Florida Bureau of Emergency Medical Oversignt. This includes material that the applicant might consider to be confidential or a trade secret. Any claim of confidentiality is waived by the applicant upon submission of this application pursuant to Section 119.07, F.S., effective after opening by the Florida Bureau of Emergency Medical Oversignt.
I accept that in the best interests of the state, the Florida Bureau of Emergency Medical Oversignt reserves the right to reject or revise any and all grant proposals or waive any minor irregularity or technicality in proposals received, and can exercise that right.
I, the undersigned, understand and accept that the Notice of Matching Grant Awards will be advertised in the *Florida Administrative Register*, and that 21 days after this advertisement is published I waive any right to challenge or protest the awards pursuant to Chapter 120, F.S.
I certify that the cash match will be expended between the beginning and ending dates of the grant and will be used in strict accordance with the content of the application and approved budget for the activities identified. In addition, the budget shall not exceed, the department, approved funds for those activities identified in the notification letter. No funds count towards satisfying this grant if the funds were also used to satisfy a matching requirement of another state grant. All cash, salaries, fringe benefits, expenses, equipment, and other expenses as listed in this application shall be committed and used for the activities approved as a part of this grant.
Acceptance of Terms and Conditions: If awarded a grant, I certify that I will comply with all of the above and also accept the attached grant terms and conditions and acknowledge this by signing below. _____ _____ Signature of Authorized Grant Signer (Individual Identified in Item 2) MM / DD / YY

THE TOP PART OF THE FOLLOWING PAGE MUST ALSO BE COMPLETED AND SIGNED.

FLORIDA DEPARTMENT OF HEALTH
EMS GRANT PROGRAM

REQUEST FOR GRANT FUND DISTRIBUTION

In accordance with the provisions of Section 401.113(2)(b), F. S., the undersigned hereby requests an EMS grant fund distribution for the improvement and expansion or continuation of pre-hospital EMS.

DOH Remit Payment To:

Name of Agency: _____

Mailing Address: _____

_____

_____

Federal Identification Number _____

Authorized Agency Official: _____
Signature Date

_____
Type Name and Title

Sign and return this page with your application to:

DOH Bureau of Emergency Medical Oversight
EMS Section, Grants Unit
4052 Bald Cypress Way, Bin A-22
Tallahassee, Florida 32399-1722

Do not write below this line. For use by Bureau of Emergency Medical Services personnel only

Grant Amount For State To Pay: $_____ Grant ID Code: _____

Approved By:_____ _____
Signature of State EMS Grant Officer Date

State Fiscal Year: 2014 - 2015

Organization Code	E.O.	OCA	Object Code
64-61-70-30-000	03	SF003	750000

Federal Tax ID: VF__ __ __ __ __ __ __ __ __

Grant Beginning Date: _____ Grant Ending Date: _____