NORTH DAKOTA RURAL EMS ASSISTANCE FUND GRANT APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 60162 (3-2015)

This completed application form and accompanying documents must be submitted to the Department of Health postmarked no later than 5 p.m. on June 1, 2015. You may attach additional pages if necessary.

Applications submitted after the deadline, sent by facsimile (fax), submitted in handwriting, or otherwise not in accordance with the application's instructions WILL NOT be accepted or considered for funding.

Please refer to the accompanying *"North Dakota Rural EMS Assistance Fund Grant Guidance"* for further detailed instructions for application completion. This grant guidance document is designed to assist you through the completion of this application and additional documents to assure eligibility.

Date of Application	
Legal Entity/Service	Federal Tax ID#
Physical Address	
City	ZIP Code
Mailing Address	
City	ZIP Code
Contact Person	
Email Address	Daytime Telephone Number
Total Amount Requested	Funding Area Number
If combining or collaborating with another funding area,list those Funding Area Numbers here.	

Checklist of Required Documentation:

Name of Squad	Prepared Financial Statements *or Financial Information Form* Included	Self-Assessment Score Sheet Included	Big Picture Updated (Personnel Roster, Vehicle Roster, and General Information)	WebCUR Information Up-to-date

Need (60 Points)

Please refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance* for detailed information regarding the completion of this section.

If professionally prepared financial statements are not provided, financial need for the funding area must be established by the completion of the *Financial Information Form* by each ambulance service within the funding area.

Financial Information Form

Ambulance Service	
Funding Area Number	
1. Please enter fiscal year end date	
2. Cash in Bank	$
3. Accounts Receivable	$
4. Equipment	

Vehicle	Year	Vehicle Cost	Cost of Equipment Added to Vehicle	Mileage

Do you own or rent your building(s)?	☐ Own	☐ Rent
If you own your buildings, what is the value of the building(s)?	$	
5. Accounts Payable	$	

List those bills that are 30 days past due

Bill	Date of Bill	Amount Owed

List those bills that are 30 days past due (continued)		
Bill	Date of Bill	Amount Owed

6. List of outstanding loans

Purpose of Loan	Payoff Amount	Monthly Payment	Number of Remaining Payments	Loan End Date

7. Revenues

Ambulance Service Fees	$
Donations/Fundraisers	$
Grants	$
Mill Levy	$
Interest Income	$
All Other Income	$
Total Revenue	$

8. Expenses

Permanent Staffing	$
Volunteer Staffing	$
Payroll Taxes [1]	$
Telephone	$
Billing Service Fees [2]	$

8. Expenses (continued)

Interest Expense	$
Office Supplies	$
Repairs	$
Insurance [3]	$
Legal & Other Professional Fees	$
Fuel	$
Facility Rent Expense	$
Utilities [4]	$
Medical Supplies	$
Bad Debt Expense [5]	$
All Other Expenses (Please List)	
	$
	$
	$
	$
	$
	$
	$
	$
Total Expenses	$
Revenues Less Expenses	$

9. Have you foregone any expenses because of funding shortages? (please list)

1.

2.

3.

10. Area of explanation (please detail any information you feel necessary)

[1] Includes employer - paid Social Security, Medicare and Unemployment
[2] Amounts paid to others to process payments to your service
[3] Include Workers Compensation, property and health insurance
[4] Include electricity, garbage, water, heating and cooling, etc.
[5] A debt owed to your service that has been determined to be uncollectible

Establish an understanding of the current state of EMS in the funding area by the completion of the *Volunteer Ambulance Service Sustainability: A Self-Assessment Tool* by each ambulance service within the funding area. See detailed instructions on the cover and page 12 of the *Self-Assessment Tool*, as well as in the *Grant Guidance* document. These documents can be found on the DEMST website: ndhealth.gov/ems

Volunteer Ambulance Service Sustainability: A Self-Assessment Tool
Score Sheet

Ambulance Service
Funding Area Number

Upon completion of the "Volunteer Ambulance Service Sustainability: A Self-Assessment Tool," each ambulance must transfer their totals for each 'Element' to this form. A score sheet for each ambulance service in the funding area must be submitted with the funding area application.

Question	A	B
Element 1: Need and/or desire for ambulance services to be volunteer		
Element 2: Local demographics and volunteering factors		
Element 3: Leadership of volunteer ambulance service		
Element 4: Culture of volunteer ambulance service		
Element 5: Sustainable numbers of active volunteers		
Element 6: Maintaining a schedule		
Element 7: Safe and human scheduling		
Element 8: Funding for the ambulance service		
Element 9: Facilities, equipment and vehicles		
Element 10: Entry / continuance barriers and recruitment		
Add up the total for each column:		

Project Description and Justification (60 Points)

Please refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance* for detailed information regarding the completion of this section.

Fully describe the project for which funds are being applied. Be as detailed as possible but try to limit the description to the area in the box. You may attach a separate document to explain in further detail if needed. Be sure all scoring elements are addressed in this description. **Include details regarding leadership and management training, including how many people have attended and what levels they have completed.**

Collaboration (60 Points)

Please refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance* for detailed information regarding the completion of this section.

Collaboration is defined as working with each other to do a task. It is a continual process in which two or more people or organizations work together to realize shared goals.

Each agency within a funding area(s) must be included in the planning process. Priority will be given to projects demonstrating participation by all ambulance services within the funding area(s). Please note that collaboration between funding areas is strongly encouraged.

If a service chooses not to participate, explain why and describe the efforts made to include them. If the service applying for this grant is the only service in the funding area, state this in the space provided, but remember to outline collaboration efforts with other entities within your funding area, i.e. QRU, fire, law, etc.

The efforts of collaboration in previous grant cycles have not been as successful as planned. In keeping with legislative intent to foster an EMS system in North Dakota, we will be significantly reducing the number of funding areas for the next funding cycle starting July 1, 2016.Therefore, current funding areas are strongly encouraged to form relationships and collaborative efforts. Consolidation of funding areas is encouraged. These efforts will be rewarded with higher scoring and therefore better chances of receiving funds and/or receiving a higher percentage of requested funds.

Project Budget Itemization

If funding for this project is approved, a monthly reimbursement request will be required using the ND Department of Health Program Reporting System (PRS).

NOTE: Each category does not need to be utilized. Unlisted categories may be specified in the 'other' category. Categories may be left blank.

Personnel/Staffing		
Travel, Food and Lodging		
Supplies		
Rent/Utilities		
Communications (Telephone/Postage)		
Equipment		
Consultant/Contractual		
Other/Optional		
Other/Optional		
Other/Optional		
Other/Optional		
Other/Optional		

Project Budget Justification

Using budgeted numbers, briefly describe in detail how monies will be spent in each category of the proposed budget.

Signature Block

The name of service and signature of an authorized representative (squad leader / board chair) of each involved entity/service is required in order for this application to be considered complete. Signature in this block verifies agreement of all arrangements/ project efforts established in this grant application.

Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date

Signature of Authorized Representative

As the person completing this application, I certify that the information contained within is true and correct to the best of my knowledge. I also acknowledge that any funds received from this grant will be expended according to the laws of the State of North Dakota for the purpose stated in this application.

Signature of Authorized Representative	Date

Submit completed application and accompanying documents to:

North Dakota Department of Health
Division of EMS and Trauma
600 E. Boulevard Ave. Dept 301
Bismarck, ND 58505-0200

All applications must be postmarked no later than 5 p.m. on June 1, 2015. Any applications received after this deadline will not be accepted. A confirmation e-mail will be sent upon receipt of this application.