



# FY 2017 Idaho Emergency Medical Services (EMS) Account III Grant Application

## **IMPORTANT INSTRUCTIONS FOR SUBMITTING YOUR APPLICATION**

Your submitted application is FINAL and only ONE application will be accepted. There are no courtesy reviews of applications; if you have questions, contact the Bureau of EMS and Preparedness PRIOR to submitting your application. The required attachments (fleet report, vendor quotes, etc.) are considered an integral part of the application. Therefore, **any omissions or errors will cause the application to be incomplete.**

The Bureau conducts a Grant Application webinar each year to help you complete the application. It is strongly recommended that you attend this webinar as it will likely answer many of the questions you may have. The webinar is recorded, so if you cannot attend live, it may be watched later. The FY2017 webinar is scheduled for March 24. Registration is open now on the grants page of the EMS website at [www.idahoems.org](http://www.idahoems.org).

If you are applying for an EMS Vehicle you will need to request a Vehicle Fleet Report from the Bureau. Verify and update the information in this report. This information will be used when processing your application and also to update your agency's licensure file. You may make handwritten notations to update the report but, be sure they are legible.

The grant application is a fillable Adobe document that can be completed using Adobe Reader ([www.adobe.com/downloads/](http://www.adobe.com/downloads/)). You can verify receipt of the application on the Grant web page at [www.idahoems.org](http://www.idahoems.org).

## **Application Due: On or before June 1, 2016**

	<b>Email - Preferred method</b>	<b>In Person</b>	<b>Mail</b>	<b>Fax</b>
<b>Submission Methods</b>	emsgrants@dhw.idaho.gov	2224 Old Penitentiary Rd Boise, ID 83712	Bureau of EMS & Preparedness PO Box 83720 Boise, ID 83720-0036	208-334-4015
	Send deadline: 11:59 p.m. June 1, 2016	Close of Business 5:00 p.m. June 1, 2016	Postmarked: June 1, 2016	Send deadline: 11:59 p.m. June 1, 2016

For Bureau Use Only

Date Received by BUREAU OF EMS & PREPAREDNESS  
Method of Receipt:

Email  Fax  In Person  Mail

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

Date & time faxed or e-mailed: \_\_\_\_\_

Date & time delivered to EMS Bureau: \_\_\_\_\_

Submit by E-mail  
(Remember Attachments)

## Section F. Required Attachment Checklist

**The following documents are attached to this application.**

*(Check applicable boxes)*

- 1. County or incorporated city government **endorsements**.
- 2. Documentation of one (1) or more **vendor price quotes** for all proposed vehicle/equipment purchases.
- 3. If requesting a new vehicle to replace an old vehicle, attach a copy of the **old vehicle's title or registration**.
- 4. If requesting a vehicle, contact the EMS Bureau for an **Agency Vehicle Fleet Report**. Update the fleet report and return with your application.
- 5. If requesting **extrication equipment**, provide a list of all personnel trained at the Extrication Operations level.
- 6. OPTIONAL: Completed and **signed W-9** to assist the Bureau in processing your award.

# FY2017 EMS ACCOUNT III GRANT FUND APPLICATION

56-1018B. EMERGENCY MEDICAL SERVICES FUND III. (1) There is hereby created in the dedicated fund of the state treasury a fund known as the emergency medical services fund III. Subject to appropriation by the legislature, moneys in the fund shall be used exclusively for the purpose of acquiring vehicles and equipment for use by emergency medical services personnel in the performance of their duties which include highway safety and emergency response to motor vehicle accidents.

## SECTION A: Agency/Financial/Demographic Information

### 1. GENERAL INFORMATION

Agency Name *(As it appears on license)* \_\_\_\_\_

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

Federal Tax ID# \_\_\_\_\_

Agency Type: \_\_\_\_\_

Registry No. Secretary of State  
*(Required for non-profit status)* \_\_\_\_\_

Name of Person Completing Application: \_\_\_\_\_

Daytime Phone # \_\_\_\_\_

Email \_\_\_\_\_

### 2. DEMOGRAPHIC

Call Volume for Calendar Year 2015 *(Idaho EMS responses only)* \_\_\_\_\_

Number of **full time** residents within your primary response area in Idaho \_\_\_\_\_

Attach county and/or city government endorsements.

*Acceptable endorsements may be from:*

- *County commissioners or incorporated city government officials (mayor, city manager, council members) within your agency's primary Idaho response area.*
- *One of the above endorsements must be the vehicle title holder if you are requesting a vehicle.*
- ***If there are multiple incorporated cities and/or counties in your primary Idaho response area, include endorsements from each.***
- *Note that multiple endorsements from the same entity (i.e. multiple county commissioners from the same county) will only count as a single endorsement.*
- *Endorsements from taxing districts are not acceptable.*

If applying for a vehicle, the name of the incorporated city or county to be the title holder.  
*(as described above - cannot be the applying agency)* \_\_\_\_\_

### 3. FINANCIAL/OPERATING INFORMATION

Provide financial operating information for one full fiscal year. This should be the most recent completed fiscal year data. Do not leave any blanks. Enter "0" if none.

Financial information provided for the period of Start Date  End Date

#### Expenses

Personnel	<input type="text"/>	\$0.00
Operating	<input type="text"/>	\$0.00
Capital	<input type="text"/>	\$0.00
Other	<input type="text"/>	\$0.00

*(Explain in narrative)*

#### Funding Sources and Revenue

Ambulance Tax District <i>(If contractual from City or County, enter under "Other")</i>	<input type="text"/>	\$0.00	Billing for EMS Services <i>(If not billing, enter "0" and explain in narrative )</i>	<input type="text"/>	\$0.00
Fire Tax District	<input type="text"/>		Number of billed calls for same time period	<input type="text"/>	
Hospital Tax District	<input type="text"/>		Donations <i>(Explain in narrative)</i>	<input type="text"/>	
General Fund <i>(City or County General Funds)</i>	<input type="text"/>		Cash on Hand <i>(Explain in narrative)</i>	<input type="text"/>	
State Motor Vehicle Fund <i>(Idaho Motor Vehicle Registration fund from county clerk)</i>	<input type="text"/>		Investment Income <i>(e.g. interest, rent, dividends, etc.)</i>	<input type="text"/>	
Grant Funds <i>(Include all grant sources)</i>	<input type="text"/>		Other <i>(Explain in narrative)</i>	<input type="text"/>	

# GUIDELINES AND IMPORTANT INFORMATION

## Applying for EMS Vehicles

*If requesting a vehicle, it must be for providing emergency medical services only. Funding for ambulances will only be awarded to those agencies having at least one ambulance transport license type. Funding for medical rescue, rescue/extrication, and/or other related purposes is also available.*

*Email [emsgrants@dhw.idaho.gov](mailto:emsgrants@dhw.idaho.gov) and request a copy of your agency Vehicle Fleet Report, update the information, and return it as an attachment to the application. Please allow five (5) business days for a response.*

*Vehicle price caps are located on page 15 of this application.*

*Firefighting vehicles, snowmobiles, boats, all-terrain vehicles, trailers, etc. will not be funded.*

## Applying for EMS Equipment

*Requested equipment must be appropriate based on clinical level of license types and associated scope of practice.*

*An equipment price cap has been set at \$20,000 per agency (and extended to \$40,000 for Multiple Organization EMS agencies as defined in IDAPA 16.01.03.200.04) in order to allow for more applicants to receive awards.*

*Extrication Equipment has been price capped at \$10,000. If you are given an award for extrication equipment, you need to submit a letter affirming that you operate at the Extrication Operations level and provide a list of all personnel trained at the Extrication Operations level. You will also need to provide the Bureau with proof of equipment-specific training after the purchase is made.*

*A group of items may be requested as one priority if it adheres to the definition of a kit. A kit is defined as "a group of items that will not work without the other pieces for a specific purpose." The "kit" must be advertised or catalogued as a kit by the vendor.*

*Communications equipment may be requested based on the number of licensed personnel listed on the most recent agency renewal application, and may be listed under one priority item request. The equipment you are requesting must be compliant with your local emergency communication system.*

*Equipment price caps are located on page 15 of this application.*

*No funding will be provided for training, firefighting equipment or disposable supplies (including epi auto-injectors). No funding will be provided for equipment necessary to perform skills associated with Optional Modules. Additional ineligible items are listed on page 16 of this application.*

***If you are awarded a vehicle you must obtain and provide documentation of appropriate insurance yearly for the life of the lien.***

***If you are awarded equipment, you must maintain it in good working order or replace it for 5 years after purchase.***

## SECTION B: Emergency Vehicle Application

If you are NOT applying for a vehicle skip to Section C

**If applying for a vehicle, please contact the Bureau to obtain an "Agency Vehicle Fleet Report" to supplement this section. Remember to UPDATE the mileage. Email [emsgrants@dhw.idaho.gov](mailto:emsgrants@dhw.idaho.gov).**

### 1. Type of Vehicle Requested

Vehicle Type

Include with my vehicle award

4x4 Option (*transport or non-transport*)

4x4 Frequency - % of calls requiring 4 wheel drive

\_\_\_\_\_

### 2. Requested Vehicle Information

Make-chassis manufacturer (*Ford, Dodge, Chevy, etc.*)

\_\_\_\_\_

Vehicle vendor/modifier (*Horton, Wheeled Coach, etc.*)

\_\_\_\_\_

Purpose (*Medical Rescue, Patient Transport, etc.*)

\_\_\_\_\_

Configuration (*Type I, II, or III Ambulance, Modified van, etc.*)

\_\_\_\_\_

Vendor Quote (*attach document*)

Amount Requested (*cannot exceed price cap*)

### 3. Mileage Type and Purpose of Similar Vehicles Currently in Use

*Review the Agency Vehicle Fleet Report obtained from the EMS Bureau and make any changes directly on the report and attach to application. This information is used in calculations, so it is important that it is current and complete.*

### 4. Age and Condition of Vehicle Being Replaced (*if applicable*)

Vehicle License Plate No.

\_\_\_\_\_

Chassis Manufacture Year

\_\_\_\_\_

Vehicle VIN Number

\_\_\_\_\_

CONDITION OF VEHICLE  Excellent  Good  Fair  Poor  Very Poor  
(*Select one*)

Plans for vehicle being replaced:

(*i.e. sold, donated, used for non-EMS purpose*)

\_\_\_\_\_

*Attach copy of vehicle title or registration for the vehicle being replaced.*

## SECTION B-1: Vehicle Description of Need Narrative Form

Agency Name

Call Volume for 2015 calendar year (*Idaho EMS responses only*)

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

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To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please mention how many vehicles are in your agency's fleet and how many miles your fleet drives annually. For nontransport vehicle requests, include the number of injury crashes your agency responded to in the last calendar year and how many of these crashes required extrication. Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

## SECTION C: Priority 1 Equipment Application

### 1. Equipment Request-Choose option A or option B

A. Item _____	Quantity=1	<i>(Quantity limited to one (1) with the exception of radios, pagers, personal protection equipment)</i>
B. Personal Protection/Communication Equipment <input type="text"/>	Quantity <input type="text"/>	

Purpose \_\_\_\_\_

Patient type for which equipment may be used \_\_\_\_\_

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)* \_\_\_\_\_

Average length of time (in minutes) the equipment would be used for a patient, *(whole numbers only, i.e. 2 hours = 120 minutes)* \_\_\_\_\_

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap)*

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

**Distance in miles to closest similar equipment:** \_\_\_\_\_

**Time in minutes to closest similar equipment:** \_\_\_\_\_

Quantity  
*(number of similar items you have - whole numbers only)* \_\_\_\_\_

Are you replacing (and removing from service) your similar items with this priority one request? \_\_\_\_\_

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description \_\_\_\_\_

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE  
*(Select one)*

Excellent     Good     Fair     Poor     Very Poor

Year Manufactured \_\_\_\_\_

3. Equipment Narrative Description of Need: Priority 1  
A detailed narrative is required for each priority request.

Agency Name

Priority 1 Item

Call Volume for the 2015 calendar year (*Idaho EMS responses only*)

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plan developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

## SECTION C: Priority 2 Equipment Application

### 1. Equipment Request-Choose option A or option B

A. Item _____	Quantity=1	<i>(Quantity limited to one (1) with the exception of radios, pagers, personal protection equipment)</i>
B. Personal Protection/Communication Equipment <input style="width: 150px; height: 20px;" type="text"/>	Quantity <input style="width: 50px; height: 20px;" type="text"/>	

Purpose \_\_\_\_\_

Patient type for which equipment may be used \_\_\_\_\_

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)* \_\_\_\_\_

Average length of time (in minutes) the equipment would be used for a patient, *(whole numbers only, i.e. 2 hours = 120 minutes)* \_\_\_\_\_

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap)*

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

**Distance in miles to closest similar equipment:** \_\_\_\_\_

**Time in minutes to closest similar equipment:** \_\_\_\_\_

Quantity  
*(number of similar items you have - whole numbers only)* \_\_\_\_\_

Are you replacing (and removing from service) your similar items with this priority two request? \_\_\_\_\_

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description \_\_\_\_\_

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE  
*(Select one)*

Excellent   
  Good   
  Fair   
  Poor   
  Very Poor

Year Manufactured \_\_\_\_\_

### 3. Equipment Narrative Description of Need: Priority 2

A detailed narrative is required for each priority request.

Agency Name

Priority 2 Item

Call Volume for 2015 calendar year (*Idaho EMS responses only*)

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

## SECTION C: Priority 3 Equipment Application

### 1. Equipment Request-Choose option A or option B

A. Item _____	Quantity=1	<i>(Quantity limited to one (1) with the exception of radios, pagers, personal protection equipment)</i>
B. Personal Protection/Communication Equipment <input style="width: 150px; height: 20px;" type="text"/>	Quantity <input style="width: 50px; height: 20px;" type="text"/>	

Purpose \_\_\_\_\_

Patient type for which equipment may be used \_\_\_\_\_

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)* \_\_\_\_\_

Average length of time (in minutes) the equipment would be used for a patient, *(whole numbers only, i.e. 2 hours = 120 minutes)* \_\_\_\_\_

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap)*

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

**Distance in miles to closest similar equipment:** \_\_\_\_\_

**Time in minutes to closest similar equipment:** \_\_\_\_\_

Quantity <i>(number of similar items you have - whole numbers only)</i>	Are you replacing (and removing from service) your similar items with this priority three request?
<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description \_\_\_\_\_

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE *(Select one)*

Excellent   
  Good   
  Fair   
  Poor   
  Very Poor

Year Manufactured \_\_\_\_\_

### 3. Equipment Narrative Description of Need: Priority 3

A detailed narrative is required for each priority request.

Agency Name

Priority 3 Item

Call Volume for the 2015 calendar year (*Idaho EMS responses only*)

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

## SECTION D: Signature Page

As an authorized representative (i.e. president, licensed EMS agency administrator) for my agency, I certify that the information provided in this application document, including any attached supplemental information, is complete and accurate.

I also understand that providing false information on any application or document submitted under these rules is grounds for declaring the application ineligible, and that any and all funds determined to have been acquired on the basis of fraudulent information must be returned to the EMS III Account.

I acknowledge that if my agency is granted an award, the funds will be mailed to the address associated with the tax ID number on file with the State of Idaho Controller's office. If an address change is required, a W-9 must be submitted with the address correction. A [W-9](#) is available on the Grants page of the Bureau website at [www.idahoems.org](http://www.idahoems.org).

Further, I acknowledge that if my agency is granted an award, my agency will be required to provide follow up documentation to the Bureau.

For all awards, this includes:

A completed Accounting Form with supporting documentation.

For vehicle awards, this includes:

A copy of the vehicle specifications at the time of the purchase contract is accepted/ executed.

Proof of obligation of funds;

Title listing the Bureau of EMS & Preparedness listed as lienholder;

Insurance certificate showing Bureau of EMS and & Preparedness listed as lienholder;  
and A completed Vehicle Replacement Form.

For extrication equipment awards, this includes:

Documentation of training on the awarded equipment within 30 days of equipment receipt.

Name of Individual Completing Application:

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Name or Signature of Person Authorizing Application:

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Title:

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Date:

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### FY 2017 VEHICLE PRICE CAPS

Vehicle Type	Price Cap
Ambulance (Transport)	\$104,500
4x4 add on request	\$4,000
Non-Transport/Rescue	\$55,000
4x4 add on request	\$4,000
Ambulance Remount	\$66,000
4x4 add on request	\$4,000

Note: Any additional expenses due to add-ons to the vehicle that are above the price cap are the responsibility of the agency.

### FY 2017 EQUIPMENT PRICE CAPS

Approved Equipment	Price Cap	Comments
AEDs	\$1,695	Base Model
Automatic Transport Ventilators	\$2,800	
Cardiac Monitors (LifePak, Zoll, etc)	\$15,000	Base Model <i>(bells and whistles not included)</i>
Computers		
Desk Top	\$650	
Lap Top	\$800	
Tablet	\$550	
Extrication Packages	\$10,000	Must have appropriate training
Gurney		
Manual	\$5,000	
Power	\$10,000	
Oxygen Cylinder Loading System	\$2,000	Portable/External models only
Pulse Oximeter (with or without CO monitoring)	\$500	Base - stand alone units <i>(NOT part of a BP Monitor Kit)</i>
Stair Chair		
Standard	\$900	
Mechanized	\$2,500	

## INELIGIBLE ITEMS LIST

The following items have been determined as INELIGIBLE by the Emergency Medical Services Advisory Committee:

1. Avalanche Beacons
  2. Digital Camera
  3. Digital laryngoscopes
  4. Disposable items (includes radio batteries, AED pads, bandaging supplies, medications, etc.)
  5. Doppler scope
  6. EMScan/Keydata Program
  7. Firefighting equipment or vehicles, snowmobiles, boats, All-Terrain Vehicles, trailers, etc.
  8. Light/Power Generators
  9. MAST
  10. Mechanical CPR Devices
  11. Portacount Respirator Fit Tester or similar devices
  12. Pulse Oximeter/Vital Sign Monitor combination device (standalone oximeters are eligible)
  13. Repeaters, Duplexers
  14. SAM Splints
  15. Structural Firefighting Turnouts
  16. Training Equipment
- NO funding for items beyond current scope of practice
  - Number of items for personnel may not exceed roster included with the most recent licensure application.