



Emergency Medical Services Grant

Submit Application to :
 Multimodal Programs
 Montana Department of Transportation
 2960 Prospect Avenue
 P.O. Box 201001
 Helena, MT 59620-1001

Due Date: _____

Date Received: _____

MDT Use only

Legal Name of Agency		Federal Tax ID #
		Emergency Medical Services License #
Authorized Fiscal Authority: _____		Contact Information Phone: Cell: Fax: Email:
(Title) (First) (Last)		
Agency Mailing Address:	Shipping Address:	Agency Physical Address:
Legal Status of Agency <input type="checkbox"/> Volunteer/Not For Profit <input type="checkbox"/> Private for Profit <input type="checkbox"/> County/City Government <input type="checkbox"/> State Agency <input type="checkbox"/> Other: _____		
Time of Service Date of beginning operation: _____		
Billing A licensed emergency medical service must bill for services at a level that is equivalent to the Medicare billing level. Does your emergency medical services bill at an equivalent to the Medicare level? <div style="text-align: right;"><input type="checkbox"/> Y <input type="checkbox"/> N</div>		

Purpose of Funding Request

- Training
- Communications
- Ambulance
- Emergency Response Vehicle
- Equipment If equipment, please define equipment.

1. **Demonstrate need for each requested equipment or vehicle or aircraft by providing information on challenges and gaps in service.** If additional space is needed please attach to application.

- A. Provide a brief statement of resources needed, including an explanation of what the resources will do to improve patient care.

B. Provide a brief statement demonstrating the need for financial assistance and applicant's ability to meet the 10% match requirement. Attach & [] ^ | a * budget [] ^ { [] • d æ ^ Á q a) & ã Á ^ ^ a Á | Á @ Á | a d Ę

[Empty box for providing a brief statement demonstrating the need for financial assistance and applicant's ability to meet the 10% match requirement.]

- C. List equipment and resources, including number, age, and mileage of emergency vehicles currently in use.

- D. Have you previously received an EMS grant from MDT? Y N

If yes, how many times have your received funding? _____


Identify gaps in service and resources needed to fill these gaps by providing information on what EMS can and cannot do with available resources. Explain how the requested resources will fill the identified gaps and the expected outcome to patients.

- E. List requested resources and lowest cost estimate. If partial funding is available, please rank items according to priority. Please provide three (3) quotes for each resource.



If a specific equipment make or model is being requested, please explain specification.

- Sole source manufacturer
- Compatibility with current equipment
- Other, please define:



- 2. In determining percentage of vehicular crash calls, please provide the following information for the previous calendar year.**

Vehicular crash calls (involving any motor vehicle): _____

Medical calls: _____

Total calls: _____

- 3. Number of paid emergency medical technicians on the active duty roster. EMT's receiving stipends or a payment per call are considered volunteer.**

Active paid EMTs: _____ Total active EMT roster (volunteer & paid): _____

- 4. Define the geographic area of coverage. Please list square mileage in addition to boundary reference points.**

- 5. Furthest distance from other emergency medical service providers within the geographic region, one-way trip.**

Other public emergency medical provider: _____ Miles: _____

- 6. Furthest distance in the service area an ambulance has to travel with a patient on board to reach the closest hospital.**

Hospital: _____ Miles: _____

Proposed Budget for Grant Funds

An eligible emergency medical service applying for a grant shall provide a ten (10) percent match for any grant funds received, MCA 61-2-503(4).

Please attach the following:

Amount Requested for Purchase (90%)	
Match Amount (10%)	
Total	

Before you submit the application, complete the following steps:

- Review the information you've provided for completeness and accuracy; and
- Make sure it is signed and dated, then mail with supporting documentation

It is not necessary to submit both an electronic and paper version of this application.

Legal Name of Agency:

Federal Tax ID:

Signatures

Officials submitting this EMS grant application indicate with signature an agreement with the following:

- Assurance to administer EMS grant program
- Assurance that match funds have been identified
- Assurance to properly maintain equipment or emergency medical vehicles/aircraft.
- Assurance to create and maintain records for three years from the date of agreement

I/We, the undersigned, do hereby attest that the information provided within this grant application is true to the best of my/our knowledge. I/We understand that this application will be disqualified should any false statements be found.

1. _____
Printed Name Title (Agency Representative)

Signature _____ Date _____

2. _____
Printed Name Title (Fiscal Officer)

Signature _____ Date _____

Please indicate the documents you'll be sending to support your application:

- Proposed statement of grant fund use
- Match funds and funding sources must be identified.
- Funding sources identified as another grant must be shown as received and secured in a financial institute.
- Supporting documentation, if applicable, i.e.-
 - AED written plan, ARM 37.104.604
 - Certification of the AED medical supervisor, ARM 37.104.601(3)
- Potential price quotes.
 - Hard copy vendor quote or online reference

Please print this page, attach it to the supporting documentation, and send it to the address listed.

EMS Grant Program
Rail, Transit and Planning Division
2960 Prospect Avenue
PO Box 201001
Helena, MT 59620-1001