NEW MEXICO DEPARTMENT OF HEALTH

EMS FUND ACT
LOCAL SYSTEM IMPROVEMENT PROJECT
APPLICATION
FOR FISCAL YEAR 2021

Due Date: November 15, 2019
Applications must be typed – handwritten and/or incomplete applications will be rejected

FOR BUREAU USE ONLY (do not write in this area)		
Date Received	**Region**	**Reviewer**

ALL APPLICATIONS MUST BE TYPED

Name of Applicant ➔ *(EMS Service/Agency)*	

Address ➔	

Contact Person ➔		
Telephone #	Fax #	Email

Fiscal Agent ➔ *(County or Municipality)*	

Address ➔	

Contact Person ➔		
Telephone #	Fax #	Email

Name(s) of other EMS Service(s) and/or communities involved in this project:	

A. Detailed Analysis of Problem/Need:

Using only the space below, describe the proposed Local EMS System Improvement Project. Include a detailed analysis of the need and a narrative showing how this project will contribute to and/or improve the Local EMS System. *(Do not attach additional sheets)*

B. Service Area Description:

Using only the space below, describe the existing EMS System for which the Local EMS System Improvement Project is being requested. Information should include a service area description, organization of the system and which services are involved (responding units, rescues, ambulances, hospital, etc). ***(Do not attach additional sheets)***

C. Project Impact:

Using only the space below, describe the impact on the Local EMS System if the project is approved, and the impact if not approved. *(Do not attach additional sheets)*

D. Cost of Project:

Item Description	Quantity	Unit Cost	Total Cost
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
PROJECT COST SUBTOTAL:			$ 0.00
Matching contribution provided by recipient/applicant (Not Required)			
- **Financial Contribution total**			
- **Financial Contribution Source(s)**			
In kind contribution description			**Value**
Total matching contribution			$ 0.00
Total amount requested from Fund Act			$ 0.00

*1. Applicant must provide an itemized report of monetary contributions to include amount, source and any special considerations.

*2. Applicant must provide quotes of items that are being purchased for this project. Please attach to application.

E. Letters of Collaboration/Support:
Letters of support from other services, entities, and stakeholders greatly strengthen the application. Each service's, entities, or stakeholder's support should be expressed in **3 or more separate** letters. **NO DUPLICATES. LETTERS WILL NOT BE ACCEPTED ONCE APPLICATION IS SUBMITTED**

F. Accountability of Previously Funded special project:
Has this service been awarded special funding (i.e., Trauma Systems, Vehicle, Local or Statewide) within the last 5 years? Please describe the status/outcome of the funded project/vehicle. **Failure to accurately disclose this information will disqualify the application.**

FY of Award	Amount	Name of Project/Description	Status

G. Service Information

Call Volume	
Federal Fiscal Year	# of Calls
Oct. 1, 20____ – Present	
Oct. 1, 20____ as – Sept. 30, 20____	
Oct. 1, 20____ as – Sept. 30, 20____	
Oct. 1, 20____ as – Sept. 30, 20____	

Service Capability	
Level	Service Number
☐ Medical Rescue	
☐ BLS	
☐ ILS	
☐ ALS	
☐ Other (_____)	

Financial Information	
Total Operating Budget	
Does your service bill for services?	☐ Yes ☐ No
Annual revenue collected	

Service Type		
☐ **Municipal**	☐ **County**	☐ **Private**

Do you provide transport? ☐ **Yes** ☐ **No**

Has your service budgeted for the maintenance/recurring expenses for this project? ☐ **Yes** ☐ **No** ☐ **N/A**

FY _____ Budget: _____	**FY _____ Budget: _____**	**FY _____ Budget: _____**

H. Project Information	
1. Have you **secured** any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
2. Have you **applied** for any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
3. Is this project listed on your community/organizations ICIP?	☐ **Yes** ☐ **No** ☐ **N/A**
If "Yes", please list project year and ranking:	
4. Can this project be phased?	☐ **Yes** ☐ **No**
5. Will phasing the project allow for each phase to allow for an independently functional component?	☐ **Yes** ☐ **No**
6. Will this project lower operational costs?	☐ **Yes** ☐ **No**
If "Yes", please explain:	
7. If the project is for equipment, how long will it be in service before replacement will be required?	
8. If the project is for training, please describe the strategy you will utilize to recruit attendees. ☐ N/A	
9. If the project is for training, please describe the strategy you will utilize to retain participants with your service. ☐ N/A	

ASSURANCES

The following are required assurances associated with your EMS Local System Improvement Project for Fiscal Year 2021.

- I certify that funds received through this distribution will be used only for the purposes and under the condition expressed in the application or its approved amendment(s);
- I certify that we will provide the support and involvement either cash and/or in-kind contributions as described in this application;
- I certify that we and the local recipient(s), understand and agree to comply with all applicable requirements of the New Mexico Department of Health; and
- I certify that the information contained in this application is true and correct to the best of my knowledge.

Chief / Director of Local EMS Service

NAME: _____ TITLE: _____
(Print / Type Name)

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ of _____, 20___
(Day) (Month)

_____
Notary Public

(SEAL)

My commission expires: _____

Mayor / Chairman County Commission

NAME: _____ TITLE: _____
(Print / Type Name)

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ of _____, 20___
(Day) (Month)

_____
Notary Public

(SEAL)

My commission expires: _____

Regional Office and Service Checklist

		Region Initial		Service Initial	
1.	All signatures on proper signature lines				
2.	All quotes attached if applicable				
3.	All Letters of Support				
4.	All notary signatures in proper place				
5.	All detailed contributions listings				
6.	All benefiting services or counties listed				
7.	Letter and approval of extension if needed				
8.	Fiscal Agent's correct mailing address				
9.	Recipient's correct mailing address				
10.	Original and 2 Copies-No special binding.				

Regional Office Reviewer

NAME: _____ TITLE: _____

(Print / Type Name)

SIGNATURE: _____ DATE: _____