A. Detailed Analysis of Problem and Need:

Using only the space below, describe in **detail** the existing problem, and the **need & rational** for this new or replacement EMS vehicle and its relationship to your operational mission. This will include the number and type of calls, the **condition** of current vehicle(s), service area characteristics, etc. **If you are proposing a Non-Transport EMS vehicle, please provide details and rationale.** ***(Do not attach additional sheets)***

B. Service Area Description:

Using only the space below, describe the existing EMS System for which the Vehicle Purchase 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 obtaining this vehicle will have on your EMS System and your county's other EMS services. Also, describe the priority ranking that this request received in the EMS Vehicle Assessment Form. (Attachment #1 to this application) ***(Do not attach additional sheets)***

D. Cost of Project:

Ambulance Type: ☐ **I** ☐ **II** ☐ **III**

Other (describe):

Vehicle Information:

☐ **2X2**	☐ **4X4**
☐ **Gasoline**	☐ **Diesel**
☐ **New**	☐ **Remount**
☐ **Replacement unit**	☐ **Additional unit**

Specifications and itemized quote must be attached to application. If custom features are quoted, please highlight or request they be quoted separately.

Unit Base Purchase Price *(No custom features)*	
25% Matching Funds (25% of base purchase price)	$ 0.00
Additional matching funds applied to base purchase price (not required)	
Source of all matching funds (required – Source & Amount)	
Amount Requested from Fund Act	$ 0.00

E. 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____	

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

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

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**

FY 19____ **Budget:** _____	**FY** _____ **Budget:** _____	**FY** _____ **Budget:** _____

F. Project Information	
a. Have you **secured** any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
b. Have you **applied** for any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
c. Is this project listed on your community/organizations ICIP?	☐ **Yes** ☐ **No** ☐ **N/A**
If "Yes", please list project year and ranking:	
d. Will this project lower operational costs?	☐ **Yes** ☐ **No**
If "Yes", please explain:	
e. How long will the vehicle be in service before replacement will be required?	
f. Please describe your vehicle maintenance program in the provided space.	

G. 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.**

All letters of support must be included with this application.
Letters will not be accepted once the application is submitted.

H. 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

ASSURANCES
FY _____ EMS Vehicle Purchase Program

- I certify that all operational and equipment costs associated with this vehicle will be provided for, and;
- I certify that the **required matching funds of at least 25% is now or will be available**, and;
- I certify that the vehicle will be purchased according to the NM State Procurement Code, and;
- I certify that the local recipient and applicant understand and agree to comply with any and all applicable requirements and regulations 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

My commission expires: _____

(SEAL)

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

My commission expires: _____

(SEAL)

EMS Agency Name: _____

- **For applications requesting a vehicle that will serve as a replacement, please provide the unit number of the vehicle targeted for replacement, a summary of the area serviced by this vehicle, and why it needs replacement. While this application is obviously for one potential replacement vehicle, please list all EMS vehicles in most need of replacement.**

- **If this application is for a new vehicle, provide a summary of the area to be serviced by the new vehicle, and a summary of the reason that potential new/additional vehicle is needed.**

- **We realize this seems redundant, but this sheet serves as a quick reference for the Statewide EMS Advisory Committee review group, as well as other reviewers.**

Vehicle Unit Number	Area Serviced	Reason for Replacement/Additional Unit
1.		
2.		
3.		

- **Please list ALL vehicles used for EMS response in your EMS service, including any needing replacement already listed above. Failure to complete this portion will disqualify your application.**

Vehicle Unit Number	Garage Address	Vehicle Make/Model	Year	Type	License Number	2 or 4 wheel dr.	Patient Capacity	Mileage
1.								
2.								
3.								
4.								
5.								
6.								

Regional Office and Service Checklist

		Region Initial		Service Initial	
1.	All signatures on proper signature lines				
2.	All price quotes attached, if applicable				
3.	All Letters of Support				
4.	All notary signatures in proper place				
5.	All detailed contributions listings				
6.	All services or counties listed that this will benefit				
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 additional copies-No special binding.				

Regional Office Reviewer

NAME: _____ TITLE: _____

(Print / Type Name)

SIGNATURE: _____ DATE: _____