AMBULANCE STAFFING GRANT APPLICATION
Grant Year July 1, 2011 to June 30, 2012

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
600 E. BOULEVARD AVE DEPT 301
BISMARCK, ND 58505-0200
Telephone 701-328-2388

NOTE: Form must be completed electronically. **No handwritten forms or faxes will be accepted.** Once you complete the form click on the print button at the bottom of the form, sign and send to the address listed above. This application must be completed in its entirety or it will be rejected.
Applications MUST BE received by **5:00PM, June 20, 2011.** Applications received after this date will not be accepted.
Please refer to Grant Guidance Handbook for further information.

Date of Application:	
Service Name:	License Number:

The purpose of this grant is to assist rural ambulance services in ensuring the availability of a minimum crew at all times. The funding is to be used as a stipend for two volunteers or paid personnel for ambulance services so they have 24/7/365 coverage. The amount of the grant award will be based on the amount requested and the number of applications received. The maximum amount of request may be **no** more than $45,000 ($22,500 for substations).

This is a reimbursement based grant. Documentation required for reimbursement includes the following:
1. Monthly schedule and roster
2. Payment list by responder
3. Call response log which includes date, location and responders
4. A copy of 1099-MISC forms and/or W2 forms for each individual receiving payment from this grant if applicable.

These forms are due to DEMST by March 1, 2012.

Person Completing Application:		
Mailing Address:		
City:	State:	Zip Code:
Phone:	Email:	
Contact Person:		
Mailing Address:		
City:	State:	Zip Code:
Phone:	Email:	

I hereby affirm and declare that the information contained on this application is true and correct and that fraudulent entries may be sufficient cause for rejection or the service may be required to return funds to the ND Department of Health. I also understand that that fraudulent entries may be considered a crime and may be prosecuted under state law.

_____ _____
Signature of Person Completing Application Date

PLEASE NOTE: If your service is approved to receive this grant at least one person (maximum 2) will be required to attend a grant recipient training session in Bismarck on June 29, 2011. You will be notified on time and location . Expenses will be reimbursed per diem.

AMBULANCE STAFFING GRANT REQUIREMENTS

Applicants must qualify by a "TRUE" response to each of the following requirements

	TRUE	FALSE
Licensed EMS operation in existance for more than 12 months	☐	☐
Bills for services at or above the Medicare base level	☐	☐
This funding will be used for staffing costs only	☐	☐
There are at least four active members on monthly roster	☐	☐
The service will be "out of service" for equipment repairs only	☐	☐
DEMST will be notified of all "out of service" requests	☐	☐
Shifts will be covered by at least two responders 24 hours/day, 365 days/year	☐	☐
At least two responders will be on a roster for each shift	☐	☐
This service does not currently provide pay for shifts **not** covered by previous staffing grants	☐	☐
All rules and regulations set forth by The North Dakota Department of Health will be followed.	☐	☐

Total Amount Requested for Grant Year $ (Please be specific)			
Local Matching Funds $	**Based upon**		Percent Match

Project Description: How will these funds be used? Please explain how providers will be compensated for shifts on your service. (Example: We will have two responders being paid $x.xx per day for ____days per week, hours per week or per call).

Click HERE to print form and mail to address listed at top of first page. Keep a copy for your records.