

Kansas Board of Emergency Medical Services Grant Programs Application

2018 / 2019 Cycle

Revolving and Assistance Fund Grant Program

Priorities for Funding

Patient Care Equipment

Patient Handling

Consideration will then be given to other requests, such as;

Training

Special Requests

Priority for funding may consider funding matches, but will be reviewed on a case-by-case basis.

**Kansas Board of Emergency Medical Services
900 SW Jackson, Room 1031
Topeka, Kansas 66612
Voice: (785) 296-7296
Fax: (785) 296-6212
www.ksbems.org**

Kansas Board of Emergency Medical Services (KBEMS) Grant Programs

The Kansas Board of EMS currently administers one reimbursement grant program, which consists of the following:

Revolving and Assistance Fund (KRAF) Grant Program

Information on the grant and line-by-line instructions for completing the application have been organized into sections for each grant program in order to make the application process easier.

GENERAL INFORMATION

All Grant Programs

Process	Independent competitive bid
Eligibility	Non-profit Licensed EMS Services
Application Deadlines	January 1, 2019
Grant Period	12 months
Grant Cycle	July 1, 2018 through June 30, 2019
Award Dates	May 1, 2019
Grant Modification	Must meet individual grant guidelines
Grant Conditions	Funding conditions may be placed on any award

PROGRAM SPECIFIC INFORMATION

KRAF Items not eligible for funding include construction costs, vehicles, fire apparatus and/or equipment, daily operational costs such as expenses for electricity, gasoline or tires, extended warranties or service agreements.

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Grant Programs

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APPLICATION PAGES

The following is a breakdown of the application pages that must be completed for the General Funds grant category. Some forms/pages are common pages and others are specific for items requested. Please make sure that all forms/pages relative to your request are complete and accurate before submission to the KBEMS.

Revolving and Assistance Fund Grant Program

- Page 1 Grant Program Application/Agency Information
- Page 2 Agency Data
- Page 3 KBEMS Revolving and Assistance Fund - Request Page
- Page 4 Affirmation – Required signatures: Agency Owner/Operator, Medical Director, and Service Director

Kansas Board of EMS Grant Program Application

Kansas Board of Emergency Medical Services

900 SW Jackson, Room 1031
Topeka, Kansas 66612

Voice: (785) 296-7296
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Agency Information

Kansas Board of EMS use only
Date received stamp

ALL ITEMS BELOW MUST BE PROVIDED

To Be Completed by Requesting Organization

Agency Name				
Email Address		Highest Level of Care Capability of Service	BLS	ALS
EMS Agency Permit No.		% of Time Each Level is Available		
Address			City	
			County	
Telephone #:			ZIP Code	
Regional Council				
Federal ID Number				
Received KRAF Funding Previously		YES, What year(s): _____ NO		
Non-profit Agency		Yes No		

KBEMS Revolving and Assistance Fund Agency Data

All agency data appearing on this page shall reflect the entire agency (including any sub-stations)

Personnel Data			
Current KBEMS Certification	Quantity	Member Status	Quantity
EMR		<u>Number of Employees/Members</u>	
EMT		Full Time (certified)	
AEMT		Part Time (certified)	
PARAMEDIC		Volunteer (certified)	
Total number of personnel		Allied Health (licensed)	
Instructor/Coordinator		Other (Support Staff)	
		Total Members	

Operational Activity: (Check all that apply)		Bill for Services	Dedicated Taxes	Gift, Grants, Donations
		Bill for Services (Maximum amount allowed under Medicare)	Other	
Type of EMS Service:	Full-Time	Combination:	Volunteer	
How many licensed ambulances: How many staff vehicles:				
Total EMS Calls (estimate) January 1, 2018 - December 31, 2018		Demographics		
BLS Calls (includes stand-bys)		Square Miles of Service Area		
ALS Calls		Population of Service Area		
TOTAL number of calls		Total Number of Stations		
Number of calls your agency was UNABLE to respond to, for any reason (define in comments section, e.g.: equipment failure, staffing, call volume, etc.)		Number of calls your agency responded to OUTSIDE of your jurisdiction		
Comments: 				

Revolving and Assistance Fund Request Page

NOTE: You will have a chance to add additional item requests after you finish up the rest of the application and click submit.

Each line item must indicate state funds requested and agency match. Refer to instructions on individual initiatives.					
General	Funding Level		Quantity Requested:	Item Requested:	Total Purchase Price
Item Code	State:	Add	_____		\$
Other (specify):	Local: _____	Replace	Current Inventory: _____		

Description (Description should include any accessories requested, identified individually with cost.)

Justification: (For primary item requested and accessories)

Current Inventory Summary: (List brand, model, year purchased, & where it's placed)

Where will this equipment be placed? If not on first out, explain:

Item Codes

1. EKG Monitor/Defibrillator
2. ALS Equipment
3. BLS Equipment
4. ALS/BLS Training Equipment
5. Computer Equipment
6. Public Information Programs or Presentations (Brochures, Videos, etc.)
7. Patient Handling
8. Other (Please specify)

Affirmation

(required for all grant submissions)

Kansas Board of Emergency Medical Services, 900 S.W. Jackson, Room 1031, Topeka, KS 66612

The agency owner/operator, service director, and medical director, whose names and signatures appear below have been designated by the agency to complete and submit a grant request on its behalf. The agency agrees to comply with the rules and regulations governing financial assistance from the Kansas Board of Emergency Medical Services for Revolving and Assistance Fund requests. In addition, the agency owner/operator and service director attest to the agency's ability to provide the matching funds (if required) to complete the purchase of the equipment, should they be awarded state funds. The agency owner/operator and service director are aware that equipment purchased with state monies must be purchased without any financial liens and without the item being used as collateral to secure a loan of any kind. The agency owner/operator and service director, by signing below, attest to the fact that the agency(s) that is affected by the possible outcome of this grant request have been notified and agree to its submission. The agency owner/operator and service director, by signing below, attest that to the best of his/her knowledge, the information contained herein with regard to the agency's financial condition is true and accurate. The medical director, by signing below, attests that he/she is aware of this request and will ensure the service's providers are sufficiently trained on any medical equipment purchased with KRAF grant funds. *The agency owner/operator, service director, and medical director signatures are required in order for this application to be considered complete.*

Request for Federal/Employer Identification Number (required)

Business Name (as shown on your income tax return)

Business name, if different from above (Doing Business As (DBA))

Address (number, street, and/or suite no. per FIN)

City, State, and Zip code _____

Employer/Federal Identification Number _____

	Agency Owner/Operator	Service Director	Medical Director
Name:			
Title:			
Phone:			
E-Mail:			
Signature:			

Point of Contact for Grant Management:

Name:

Agency:

Phone:

Email:

Application Date:

Brief Project Description:
