Kansas Board of Emergency Medical Services
Grant Programs Application

2013 / 2014 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;
Communications
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
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www.ksbems.org

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	February 7, 2014
Grant Period	12 months
Grant Cycle	July 1, 2013 through June 30, 2014
Award Dates	May 1, 2014
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.

Priorities for Funding

Patient Care Equipment
Patient Handling

<u>Consideration will then be given to other requests</u>:
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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. The KRAF Priorities Questionnaire must be completed if you have identified a program priority for funding.

Revolving and Assistance Fund Grant Program

Page 1 Grant Program Application/Agency Information
Page 2 Agency Data
Page 3 Financial Information for Licensed Ambulance Services
Page 4 KBEMS Revolving and Assistance Fund - Request Page
Page 5 Technical Information for the purchase of Radio Communications Equipment (required when applying for communications equipment)
Page 6 KRAF Priorities Questionnaire
Page 7 Affirmation – Required signatures: Agency Owner/Operator, Medical Director, and Service Director

Kansas Board of EMS Grant Program Application

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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				
EMS Agency Permit No.		Highest Level of Care Capability of Service	☐ **BLS**	☐ **ALS**
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		**Number of Employees/Members**	
EMT		Full Time (certified)	
AEMT		Part Time (certified)	
EMT- I, EMT-I/D, EMT-D		Volunteer (certified)	
PARAMEDIC		Allied Health (licensed)	
Total number of personnel		Other (Support Staff)	
Training Ofiicer I			
Training Officer II			
Instructor/Coordinator		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, 2013 - December 31, 2013		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, ex.: (equipment failure, staffing, call volume, etc.)		Number of calls your agency responded to OUTSIDE of your jurisdiction	

Comments:

Expenditures/Expenses budgeted for the requested fiscal years

EMS Budget **(Related to EMS Operations Only)**	**Actual FY 2013 Budget**	**Estimate FY 2014 Budget**	**% Change (+/-)**
Personnel Costs Salary & Benefits			
Operating Expenses Utilities, Supplies & Equipment Contractual Services Leases and Rentals			
Capital Expenses Apparatus/Equipment > $5,000			
Total EMS Budget			
KBEMS Aid to Locals (EIG, KRAF, Regional Funding)			
Donations, Contributions, Bequests, Memorials, Etc.			
Investments			
Grants (from any source)			

Describe Expenses

EMS Budget (Revenues**)**	**Actual FY 2013 Budget**	**Estimated FY 2014 Budget**	**Change (+/-)**
Available Funds			
Expenditure Limitation			

Describe Revenue

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 Other (specify):	State: Local: _______ 100%	Add Replace	_______ Current Inventory: _______		$

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

Justification: **(For primary item requested and accessories)**

Item Codes

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

Revolving and Assistance Fund
Technical Information for the purchase of Radio Communications Equipment

IMPORTANT: Must Be Completed For Any Request For Base, Mobile, or Portable Radios or for Pagers or Alerting Receivers (Equipment only)

All Requested Communications Equipment must be listed on the "Grant Application"

AGENCY FREQUENCY PLAN & CHANNEL CONFIGURATION ***(REQUIRED FOR ALL RADIO REQUESTS)***

1. Used by attendants on service roster? ☐ **YES** ☐ **NO, please explain:** ______________________

____

2. Radio is P25 Compliant? ☐ **YES** **NO, please explain:** ______________________

____

Current inventory of requested Communications Equipment
(Required for all requests)
(List similar items by group, i.e., Mobile Radios, Portable Radios, Minitor Pagers (All Types); List Different Bands On Separate Lines)

CATEGORY OF EQUIPMENT REQUESTED	BAND (LB, VHF, UHF, 800)	PRESENT INVENTORY	%	PLAN TO PURCHASE	&	PLAN TO REASSIGN OR DISPOSE	=	TOTAL
							=	
							=	
							=	
							=	
							=	
							=	
							=	

COMMENTS:

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KRAF
REQUEST JUSTIFICATION QUESTIONNAIRE

APPLICANT INFORMATION

AGENCY NAME: ______________________ DATE: ______________

PROJECT TITLE: ______________________

1. PLEASE GIVE A BRIEF DESCRIPTION OF THIS PROJECT (2-3 SENTENCES).

2. WHAT ARE THE SPECIFIC OBJECTIVES OF THIS PROJECT AND ANTICIPATED TIME FRAMES?

3. EXPLAIN ANTICIPATED IMPACT OF THIS PROJECT ON AGENCY, CUSTOMER SERVICE, OR COMMUNITY. WHO WILL BENEFIT FROM THE PROJECT?

4. WHAT DO YOU EXPECT WILL BE THE TWO MOST CRITICAL ISSUES OR CHALLENGES FACING YOUR AGENCY IN COMPLETING THIS PROJECT?

5. DOES YOUR AGENCY HAVE ADEQUATE RESOURCES (money, equipment, facilities, personnel, etc.) TO ACHIEVE THE GOALS OF THIS PROJECT?

6. DESCRIBE HOW YOU WILL EVALUATE WHAT CHANGES OR POSITIVE PROGRESS CAN BE DIRECTLY LINKED TO THIS PROJECT.

IMPORTANT NOTICE

This questionare is required to be completed in full for each project/different item requesting KRAF Grant funds. Your application will noted be considered for award if the KRAF Request Justification Questionare is incomplete or absent.

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:**

Brief Project Description: