KANSAS BOARD OF EMERGENCY MEDICAL SERVICES
REVOLVING AND ASSISTANCE FUND GRANT
(KRAF) GRANT APPLICATION INSTRUCTIONS

Application Form is to be filled out by the Non-profit Licensed EMS Service who is submitting data in KEMSIS or actively pursuing submission. **Complete the Application Form in its entirety using Survey Monkey (link will be emailed to all service directors). Any application that is incomplete or does not include ALL required items will be denied without further consideration.**

Step 1. Agency Information

- Your Name – Enter the name of the person completing the application.
- Service Name – Enter the name of the applying service.
- Your Email Address – Enter the email for the person completing the application.
- Your Contact Phone Number – Enter the phone number for the person completing the application.
- Agency Name – Enter the name of the applying agency/organization.
- EMS Agency Permit Number – Enter your EMS agency number.
- Address, City, State, Zip, County, Telephone # - Address at which the agency receives its mail. This address cannot be an individual member's home address.
- Email Address – Enter a current and valid email address for contact and application completion.
- Regional Council - All areas of the state are serviced by a regional EMS council office.
- Federal ID Number (FEIN) - Each agency must have an individual Federal Identification Number. Auditing requirements will not allow payments to be made to any organization that does not have a FEIN. The use of another organization's FEIN is not acceptable.
- Highest Level of Care Available - Licensed EMS agencies hold a certification at either the BLS or ALS level of care.
- Level of Care Availability – Enter the % of calls care is provided at the BLS and ALS level.
- Received KRAF Funding Previously – Indicate if KRAF funding had been received previously and list each fiscal year (FY). (July 1-June 30)

Step 2. Personnel Data

Current KBEMS Certification - List each member only once.

- EMR - Those providers holding the certification of FR or EMR.
- EMT - Those providers holding the certification of EMT.
- AEMT – Those providers holding the certification of AEMT.
- Paramedic - Those providers holding the certification of Paramedic.

Member Status

- Full-time - The number of certified personnel that are considered full-time (paid personnel).
- Part-time – The number of certified personnel that are consider part-time (paid and working < 999 hours annually).

- Volunteer - The number of certified personnel that are volunteers. (Receive only reimbursement for expenses.)
- Allied Health – The number of licensed allied health staff.
- Other – Support Staff

Step 3. Operational Activity **(**method/s by which the service is funded).

- Operational Activity Support – Check all that apply
- Type of EMS Service - Indicate which best describes your agency: full-time, volunteer, or a combination.
- How many licensed ambulances – The number of units (ambulances) operated by the service (licensed or stand-by)
- How many staff vehicles – How many staff vehicles are owned/operated

Total EMS Calls

- BLS Calls (including stand-bys) - Total number of calls recorded as Basic Life Support call.
- ALS Calls - Total number of calls recorded as Advanced Life Support call.
- Number of calls your agency was UNABLE to respond to, for any reason - This total should include those related to mechanical failure, lack of equipment, lack of certified attendants, etc.
- Why were you unable to respond – Describe situations that caused your agency to be unable to respond.

Demographics

- Square Miles of Service Area - Total square miles of service area covered by your agency.
- Population of Service Area - Total population of service area covered by your agency.
- Total Number of Stations - Total number of stations operated by your agency including sub-stations.
- Number of calls your agency responded to OUTSIDE of your jurisdiction – This total should include calls for mutual aid, etc.

Step 4. Request Page

- Item Code – Enter item code for the item being requested. For Other, please specify in space provided.
- Funding Level Percentage - Indicate at what level your agency is seeking funding from the state for each item requested. State % is "first" percent number, Local % is "second" percent number. Applications for grant funding will be prioritized by the local match percentage. AGAIN THIS YEAR: **A minimum of 15% local match is required for all equipment. If the minimum can't be met, compelling information should be provided to justify a lower local match. Also, applications can be for a cot or loading system, but not both.** **AGAIN THIS YEAR**: All monitor requests have a **minimum** 25% local match with a maximum state share of $20,000. **AGAIN THIS YEAR:** CPR devices and cots will have a **minimum** 25% local match requirement.
- Add/Replace - Indicate if the item that is being requested is a replacement, or

additional equipment.

- Quantity - Indicate quantity being requested. (If quantity is more than one, additional question of accepting less than total quantity if Board awards less than total requested.)
- Current Inventory - Indicate the number of items being requested that are currently owned by the agency. This number will include items that are similar to those items being requested. (Example: An agency requesting 2 - Zoll X Series Monitor/Defibrillator yet has 1 - LifePak 1000 and 1- LifePak 500 in their inventory would place a 2 in this block.)
- Item Requested - Provide a *brief* description of the item being requested.
- Total Purchase Price - Indicate the total amount of the item(s) being requested. Description – Should include any accessories requested, identified individually with cost.
- Justification - The narrative section provides the agency with the opportunity to explain their agency's need for the item(s) requested and the impact it will have on their agency and/or service area. Do not forget to include the need for hardship funding, if so requested.
- Current Inventory Summary – Provide the brand names, models, years purchased, and where items are placed for items similar to those requested.
- Where equipment will be placed – Be specific to identify where the requested equipment will reside. If it will not be on the first out vehicle, please give an explanation.
- Select DONE to submit your survey application. Use PREV to go back and make changes before selecting done. Once submitted, the contact email will be sent a PDF of the application.

Step 5. Affirmation

The affirmation is a statement that indicates that the Authorized Agent and Financial Officer have truthfully, and to the best of his/her knowledge, completed this application accurately. A link to the affirmation is provided on the KRAF website. Print the Affirmation page, get the required signatures and ***send the signed form to the board office (emailed or faxed is acceptable).***

- Business Name – The licensed ambulance service.
- Business Name (if different) – If DBA, the name of the licensed ambulance service.
- Address – Address of licensed ambulance service.
- City, State, Zip – The City, State, and zip code of the licensed ambulance service.
- FEIN – Federal Employer Identification Number associated with the licensed ambulance service through the Operator.
- Agency/Organization Authorized Agent - The authorized agent is the person responsible for the operation of the service (person or municipality who has a permit to operate an ambulance service).
- Service Director – The service director is the person responsible for the service.
- Medical Director – Name of the Medical Director.
- Printed name of the Authorized Agent, Service Director, and Medical Director - Print the name of the authorized agent, service director and OMD.
- Title - Provide the title of the authorized agent, service director, and OMD
- Phone – Phone number of the authorized agent, service director, and OMD
- Email address: A current and valid email address of the authorized agent, service

director, and OMD.

- Point of Contact for Grant Management. Name, Agency (licensed service), phone, and email address of an individual to be utilized as the contact by KBEMS regarding questions of the grant application.

Failure to submit all applicable information by the deadline will result in disqualification of the application.

CHECKLIST

- Complete entire KBEMS Application Form and submit electronically – ***required***

- **AGAIN THIS YEAR**: KBEMS secured quotes from various vendors for cardiac monitors, stair chairs, RAD-57, cots and automatic CPR devices. Please use these quotes and select the accessories that meet your needs to form your total request per item.

- Submit Vendor Quote for all requested items and send to: kraf@ks.gov – ***required***
  Please provide on the Subject Line: Service name and individual submitting document

  Each quote must break out accessories separately. Each quote must be valid for at least six (6) months. ***required***

- Submit Request for Modification for Used/Refurbished Equipment to: kraf@ks.gov – ***if applicable***
  Please provide on the Subject Line: Service name and individual submitting document

  If requesting to purchase an item that is not new, a request for modification must be submitted in writing. "Used/Refurbished" must be shown on the quote and "KBEMS" and the board address must be included in the purchaser name.

- If not using a quote already provided on KBEMS website, submit KRAF "New Vendor Product Request Form" (see KSBEMS.org website) and quote to: kraf@ks.gov – ***if applicable***
  Please provide on the Subject Line: Service name and individual submitting document

  If requesting to purchase an item through YOUR vendor, you will need to complete this form. Provide the vendor quote on vendor letterhead. Each quote must break out accessories separately. Each quote must be valid for at least six (6) months.

- Submit KRAF "Agreement of Service" (see KSBEMS.org website) to: kraf@ks.gov– ***required***
  Please provide on the Subject Line: Service name and individual submitting document

Also, send an email to suzette.smith@ks.gov to verify your submission was received.

Review Process

1. Applications will be initially reviewed by KBEMS Staff for completeness. Items will be reviewed to ensure compliance with the grant priorities for funding, i.e., requests will be reviewed to verify that Service is submitting data via the Kansas Emergency Medical Services Information System (KEMSIS). Incomplete applications will be denied.
2. KBEMS will provide all documentation to the Assistance Review Committee (ARC) members for review. The ARC will grade each request and prepare their proposal for approval.
3. The ARC will provide comments and grades for each requested item and return this documentation to KBEMS. Data is then entered into the office spreadsheet for tabulation. The ARC will conduct a public meeting before the regular April KBEMS meeting to review the requests that received a viable funding grade. Information may be provided or requested concerning requests announced for funding from those attending the meeting. Applicants are encouraged to contact their Region representative to discuss individual requests.
4. The Committee reserves the right to recommend a request be partially funded or to place a condition of funding on any award.
5. A report of the requests that are recommended for funding will be submitted to the KBEMS Executive Director to be presented to the full Board for ratification.
6. Following the regular April KBEMS Board Meeting, KBEMS will mail written notification to those agencies who were approved for funding and those who were not approved.

Awardee responsibility

Those agencies receiving notice of awarded funds will be required to notify KBEMS of the acceptance of the award, submit the order for the equipment by June 15th, and submit the invoice to KBEMS upon receipt of the equipment. Once the equipment is received and KBEMS receives the invoice, KBEMS will issue a check **to the service** for the state portion of the grant award.