Illinois Department of PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

Division Of Emergency Medical Systems & Highway Safety

Emergency Medical Services Assistance Fund Grant Application Cover Page

Name of Organization _____

EMS Region Number _____ EMS System Name _____

FEIN # __ __ - __ __ __ __ __ __ __

Address _____

City _____ State IL ZIP Code + 4 _____ - _____

Primary Contact Person _____

Telephone # _____ E-mail _____

Secondary Contact Person _____

Telephone # _____ E-mail _____

Current funding source for your organization _____

If your organization is an ambulance provider, please answer the following:

Level of Service _____ Population of Service Area _____

Total Yearly EMS Calls BLS _____ ILS _____ ALS _____

# of Licensed Personnel BLS _____ ILS _____ ALS _____

Status of Personnel Volunteer _____ Paid _____ Paid On Call _____

Individual Who Prepared This Application _____

_____ _____

Signature of Individual Who Prepared This Application Date Signed

Description Of Project Criteria

1. Completely describe your agency/organization's request for financial assistance. Describe the **purpose** and **scope** of the request. Please state clearly your **justification** for the requested item(s).

2. Will funding of this request maintain present services? If requested item(s) is for replacement purposes, describe current condition of item(s) to be replaced.

3. How does the requested item(s) impact the citizens served and on **patient care**?

4. Is the requested item(s) required for licensure and/or certification pursuant to the EMS Systems Act and/or the EMS and Trauma Center Code?

5. Is the item(s) requested necessary for an upgrade in services, i.e., BLS to ALS?

6. Is the requested item(s) to be shared with other EMS agencies? Is the request identified in local, regional, and/or state plans/documents as a priority? Is the request compatible with goals and objectives of the applying agency/ organization, jurisdiction, region and/or state?

7. Provide any additional information that will help the reviewers understand your need for the requested item(s), e.g., what are the unique characteristics of your service area relating to geography, demography, economic conditions, etc.

Evaluation Criteria

1. Requested item/project is required for licensure and/or certification by the EMS Systems Act and/or EMS and Trauma Center Code.

   ☐ YES
   ☐ NO

2. Equipment requested is required for upgrade, i.e., BLS to ALS. A statement of endorsement from local EMS System supporting upgrade ***must*** be included.

   ☐ YES
   ☐ NO

3. Current personnel are trained to operate requested items.

   ☐ YES
   ☐ NO

4. Requesting agency serves more than its own service area, and an increasing number of calls are out of its own district.

   ☐ YES
   ☐ NO

5. Equipment requested is to be shared with other EMS agencies.

   ☐ YES
   ☐ NO

6. The request is identified in local, regional and/or state EMS plan(s) as priority. Include impact on citizens served. The program/equipment request is compatible with goals/objectives of the agency and the EMS Region.

   ☐ YES
   ☐ NO