Illinois Department of PUBLIC HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

422 South Fifth Street, Fourth Floor • Springfield, Illinois 62701-1824 • www.idph.state.il.us

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
EMERGENCY MEDICAL SERVICES (EMS) ASSISTANCE FUND
GRANT GUIDANCE AND APPLICATION

GENERAL REQUIREMENTS

Any Illinois licensed/designated EMS participant that provides EMS service within the State of Illinois may apply for funds through their Regional EMS Advisory Committee.

1. Applications must be submitted on the EMS Assistance Fund Grant application form supplied by the Department.

2. Programs, services, and equipment funded by the EMS Assistance Fund must comply with the Emergency Medical Services (EMS) Systems Act and the Regional EMS Plan in which the applicant participates.

3. **All applications from providers must be submitted to their respective Regional EMS Advisory Committee by the deadline required by each Regional Committee. No applications will be accepted by the Department directly from an applicant.**

4. A financial statement must be submitted to be eligible to receive a grant.

5. EMS providers must submit a copy of their current license.

5. Deadline for submission of applications and review abstracts identifying the recommendations and prioritization rankings from each Regional EMS Advisory Committee to the Department is June 28, 2013.

6. All award recipients are required to enter into a grant agreement as prescribed by the Department.

7. Funds might not be equally divided among the eleven regions; consequently, award decisions will not be made based on financial parity among regions.

INSTRUCTION FOR COMPLETING APPLICATION

1. TYPE or PRINT with black ink (blue, red or other colors of ink do not duplicate well).

2. If requesting more than one item, prioritize items in the Description of the Project section in the event a portion of the request may be granted.

3. List each item requested with projected cost.

4. Applications that include requests for more than one agency (i.e., regional, local, association or jurisdictional requests) must list each agency separately, the item(s) being requested for each agency, and include a completed data sheet and financial statement for each agency.

5. **Applications must be submitted to the respective Regional EMS Advisory Committee by the deadline established by your region.**

6. Applications shall contain these required components. Applications lacking any of these components may be precluded from consideration:

    - Fully completed **Grant Application**.

    - Description of project consistent with **Description of Project Criteria**.

    - Description of the applicability of the **Evaluation Criteria** for the particular requests.

    - Self-assessment according to **Grading Scale**.

    - Any additional information regarding the request and information that would support this need. This should include a detailed list of how the grant funds will be spent.

7. Due to limited amount of grant funds available, the Department will not consider applications for new vehicles, vehicle re-chassis, building projects or grant requests over $5000.00.

8. If you require assistance in the preparation of your grant application, contact the Department's Regional EMS Coordinator for your Region.

GRADING SCALE

Grade 1 **Immediate Funding Need—**Alternate funding sources exhausted or unavailable. System will suffer if program postponed. Program request is of greatest impact to citizens served.

Grade 2 **Definite Funding Need—**Alternative funding limited or delayed availability. Program of high priority. Need is present. Program of high impact to citizens served.

Grade 3 **Project Needed Eventually—**Local funding available in future. System will benefit from improved time table. Limited available funding.

Grade 4 **Project Can Be Delayed—**Local funds available. Program of low impact to citizens served. Consideration will be given as need increases.

Grade 5 **Project Not Needed—**Local funds available. Limited or impact to service area. Duplication of resources. Consideration will be given as needed is evident.

FOR IDPH Use Only
Application No. _____

Date Received _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Office of Preparedness and Response
Division of EMS and Highway Safety/EMS Assistance Fund Grant

Section 1. APPLICANT INFORMATION	
Legal Name of Applicant: *(Attach copy of W-9)*	
Name and Title of Chief Officer: ***(****If more than one, attach a list of all officers)*	Name: Title: Address: Phone: Fax: E-mail:
Applicant Address:	
City, State, Zip Code:	
Telephone:	
Fax:	
E-Mail:	
Web Site:	

Section 2. APPLICANT GRANT HISTORY	
Description of Applicant Organization: *(200 Character Maximum)*	**An Illinois licensed and based EMS provider agency that provides EMS service within the State of Illinois.**
Has this Applicant received a grant from the federal government or the State of Illinois within the last 3 years?	☐ **YES** ☐ **NO**
If yes, provide the following: *(Add additional rows if needed)*	Agency providing grant funding: Grant Number: Grant Amount: Grant Term: Brief Description of grant:
How long has Applicant been incorporated?	

Is the Applicant in "good standing" with the Illinois Office of the Secretary of State?	☐ **YES** ☐ **NO**
Has the applicant or any principal experienced foreclosure, repossession, civil judgment or criminal penalty (or been a party to a consent decree) within the past seven years as a result of any violation of federal, state or local law applicable to its business?	☐ **YES** ☐ **NO** If yes, identify the nature of the action and the disposition. If the action/proceeding is still pending or unresolved, provide a status identifying the unresolved issues. Be as descriptive as possible.
Is the applicant or any principal the subject of any proceedings that are pending, or to the best of the applicant's knowledge threatened against applicant and/or any principal that may result in any adverse change in applicant's financial condition or materially and adversely affect applicant's operations?	☐ **YES** ☐ **NO** If yes, identify the nature of the proceedings and how they may affect the applicant's financial situation and/or operations.
Does the applicant or any principal owe any debt to the State of Illinois?	☐ **YES** ☐ **NO** If yes, list the amount and reason for the debt. Attach additional documentation to explain the debt owed to the state.

Section 3. APPLICANT ORGANIZATION INFORMATION

Legal Status:	☐ Individual ☐ Sole Proprietor ☐ Partnership/Legal Corporation ☐ Tax Exempt ☐ Corporation providing or billing medical and/or health services ☐ Corporation NOT providing or billing medical and/or health services ☐ Other (describe):	☐ Governmental ☐ Nonresident alien ☐ Estate or Trust ☐ Pharmacy (Non-Corporation) ☐ Pharmacy/Funeral Home/Cemetery (Corporation) ☐ Limited Liability Company (select applicable tax classification) ☐ D = Disregarded Entity ☐ C = Corporation ☐ P = Partnership
Federal Tax Payer Identification (FEIN) Number or Social Security Number (SSN) of Applicant if not an organization:		
If applicable, list all Names and FEINS that are registered to your organization or have been registered during the last 3 years.	**Name:**	**FEIN:**
	Name:	**FEIN:**
	Name:	**FEIN:**

DUNS Number:	
Illinois Department of Human Rights Number (if applicable):	
Legislative Senate District:	
Legislative House District:	
Congressional District:	

Section 4. KEY GRANT CONTACT INFORMATION	
Grant Application Contact/Title:	
Telephone:	
Fax:	
E-Mail:	
Fiscal Contact/Title:	
Telephone:	
Fax:	
E-Mail:	

Section 5. GRANT PROJECT PROPOSAL	
Project Title:	**EMS Assistance Fund Grant**
Brief Project Description: *(350 character maximum). Note that the Scope of Work must be completed separately.*	**This project provides for distribution of moneys in the EMS Assistance Fund to each of the eleven Regions in the State in accordance with protocols established in each Region's EMS Region Plan.**
Project Period: *(Include start and end date)*	**July 1, 2013 through June 30, 2014**
Total Amount of Funding Requested from IDPH:	

Total Applicant Match or In-Kind Contribution:	**Not Applicable**
If subcontractors will be used under this grant application, provide name, address and description of services. **Not Applicable**	Subcontractor name: Address: City, State, Zip: Phone: Description of services: Subcontractor name: Address: City, State, Zip: Phone: Description of services:

Section 6. GRANT BUDGET SUMMARY *(Note: This section is for summary purposes only. A detailed budget is/may be required. See Section 7)*		
Budget Line Items Requested	**Requested Grant Budget Amount**	**Applicant Match of In-Kind Contribution**
Personal Services *(Includes Salary and Wages)*	**Not Applicable**	**Not Applicable**
Fringe Benefits (Percent use for calculation _____%)	**Not Applicable**	**Not Applicable**
Contractual Services (detailed information about the contractual services amount must be submitted on the attached budget excel form)	**Not Applicable**	**Not Applicable**
Travel	**Not Applicable**	**Not Applicable**
Commodities/Supplies		**Not Applicable**
Printing	**Not Applicable**	**Not Applicable**
Equipment		**Not Applicable**
Telecommunications	**Not Applicable**	**Not Applicable**
Patient/Client Care	**Not Applicable**	**Not Applicable**
Grand Total		**Not Applicable**
If the proposed budget includes Personal Services (Salary or Wage) related costs, please indicate the type of documentation that will be maintained and used to allocate staff costs to the grant. **Not Applicable**	☐ Time Sheets ☐ Cost allocation plans ☐ Certifications of time allocable to grant ☐ Other, please describe _____ ☐ Not applicable to this grant application	

Section 7. GRANT SCOPE OF WORK

EMS Region Number _____ EMS System Name _____

Current funding source for your organization _____

Copy of current providers licensed attached **Yes** ☐ **No** ☐ **If no, reason** _____

Agency's Financial Statement Attached **Yes** ☐ **No** ☐ **If no, reason** _____

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 _____

Number of Licensed Personnel BLS _____ ILS _____ ALS _____

Status of Personnel Volunteer _____ Paid _____ Paid on call _____

Description of Project Criteria

1. Completely describe your agency/organization's request for financial assistance. Describe the **purpose**, **scope** and **amount** of the request. Please state clearly 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, and region and /or state?

7. Provide any additional information that will help the reviewers to 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 area, and an increasing number of calls are out of its own district.

   YES ☐
   NO ☐

5. Equipment requested is to be shared with the 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 ☐

Provide any additional information that will help the reviewers understand your need for the requested Item(s).

Section 3.220 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50/] requires the Illinois Department of Public Health to distribute money from the EMS Assistance Fund to the 11 EMS Regions for the purposes of organization, development and improvement of Emergency Medical Services Systems….

The grant cycle runs from July 1-June 30 of each year. All funds remaining at the end of the period of time grant funds are available for expenditure (June 30 of the fiscal year the grant was awarded) shall be returned to the State within 45 days.

Quarterly objectives do not apply as the grants are for the purchase of equipment and education. Once the equipment is bought and education completed the objective is met. The EMS Agencies have the grant cycle to purchase and complete education funded by the grant.

The review abstract for each application completed by the EMS Regional Advisory Board are considered the letters of support.

Measurements and outcomes of this grant will be met by showing timely response to EMS calls, proper use of equipment, education of new equipment, educational objectives completed.

Objectives of this grant will be to purchase any equipment requested and complete any education as requested.

Expected outcomes and goals of this grant are to help improve EMS services and increase education to EMS personal.

Outcomes will be measured by reporting in accordance with requirements for data collection and submission pursuant to 77 Ill. Adm. Code 515.350 (Emergency Medical Services and Trauma Center Code − Data Collection and Submission).

Name of Grant Program EMS Assistance Fund Grant

Legal Name of Applicant _____

Section 8. APPLICANT CERTIFICATION

Under penalty of perjury, I certify that I have examined this application and the document(s), proposal(s), and statement(s) submitted in conjunction herewith, and that to the best of my information and belief, the information contained herein is true, accurate, correct, and complete. I represent that I am the person authorized to submit this application on behalf of the applicant, and that I am authorized to execute a legally binding grant agreement on behalf of the applicant if this grant application is approved for funding.

I, hereby release to IDPH, the rights to use photographs and/or written statements of information, regardless of the format, contained in or provided after the grant application for the purposes of publication on the IDPH web site, unless the applicant submits a written request asking that the information not be disclosed.

Signature	Printed Name/Title	Date

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Type of Grant Application

Direct Appropriation	☐
Allocation by Administrative Rule	☐
Competitive Request for Application	☐
Statutory Board Review Required	☐
Formula and/or Caseload Allocation	☐
Non-Competitive	☐

Funding Source:

General Revenue Fund	☐
State Special Fund	☐
Federal	☐

Grant Application Funding Recommendation by Division/Program:

☐	Grant Application Disqualified/Not Eligible for Funding under this Award
☐	Grant Application Recommended for Funding at Full Request
☐	Grant Application Recommended for Funding at $_____.

Division Chief/Program Manager: _____ Date: _____

Grant Application Funding Recommendation Approved by:

Deputy Director _____ Date: _____

Grants Review Committee Score: _____ (Full review grants only)

Assistant Director _____ Date: _____