

**Competitive and Per Capita Grant Application FY 2016  
Bureau of Emergency Medical Services and Preparedness  
This form should be typed or computer generated**

**LIMIT OF 2 ITEMS**

**Agency Information:**

Name of Agency: \_\_\_\_\_ EMS Provider Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
 City: \_\_\_\_\_ County \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Agency Telephone No. \_\_\_\_\_

LEVEL OF LICENSURE:                      Licensed                                      Designated                                      First Responder

Priority One  
Item : \_\_\_\_\_  
Priority Two  
Item: \_\_\_\_\_

Units	Unit Price	Total	Local Match	State Share
TOTAL				\$

**DEMOGRAPHIC INFORMATION  
Demographic information MUST be completed**

1. For Ambulance Services: Indicate the call volume of agency last year:  
 EMS Calls: (ambulance, paramedic, First Responders only) \_\_\_\_\_  
 Dispatch agencies MEDICAL CALLS only (no fire or law enforcement calls): \_\_\_\_\_
2. Indicate number of stations within the provder agency: \_\_\_\_\_
3. How many counties does the agency dispatch: \_\_\_\_\_
4. Indicate the percent of responses to non-residents of service area: \_\_\_\_\_ %
5. Indicate number of interstate freeway miles in agency service area: \_\_\_\_\_
6. Furnish information about the agency:
  - a. Square miles of service area: \_\_\_\_\_
  - b. Population of service area: \_\_\_\_\_
  - c. Type of terrian: (desert, mountain, marsh land, etc.) \_\_\_\_\_
  - d. Type of area: \_\_\_\_\_
    - \_\_\_\_\_ Subfrontier or Frontier
    - \_\_\_\_\_ Rural area
    - \_\_\_\_\_ Urban area
  - e. Amount of per capita funding received for FY2015: \$ \_\_\_\_\_
7. Furnish information about partnerships/collaboration and mutual aid agreements with other agencies. List agencies:

**TRAINING EQUIPMENT GRANT JUSTIFICATION FY2016 - Category 1**

**Bureau of Emergency Medical Services and Preparedness**

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**Agency Information:**

Name of agency: \_\_\_\_\_ EMS Provider No. \_\_\_\_\_  
Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
City: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Agency Telephone No. \_\_\_\_\_

Items Requested:	Units	Price	Total	Local Match	State Share

JUSTIFICATION: When training equipment is requested, a copy of the vendor equipment information items requested must be attached.

**DEFIBRILLATOR GRANT JUSTIFICATION FY2016 - Category 2**  
**Bureau of Emergency Medical Services and Preparedness**  
**This form should be typed or computer generated**

**Agency Information:**

Name of agency: \_\_\_\_\_ EMS Provider No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Zip Code; \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Agency Telephone No. \_\_\_\_\_

Items Requested:	Units	Price	Total	Local Match	State Share

**JUSTIFICATION:**

Please include in the justification how many defibrillators you presently own, the type and the age of each.  
 (Refer to page 3 of the Guidelines.)

**COMMUNICATION GRANT JUSTIFICATION FY2016- Category 3**  
**Bureau of Emergency Medical Services and Preparedness**  
**This form should be typed or computer generated**

**Agency Information:**

Name of agency: \_\_\_\_\_ EMS Provider No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Agency Telephone No. \_\_\_\_\_

Items Requested:	Units	Price	Total	Local Match	State Share

ALL COMMUNICATIONS EQUIPMENT MUST BE REVIEWED BY Dan Camp, Bureau Communications specialist, before March 20, 2015, otherwise the request will not be considered.  
 Dan can be reached at: (801) 273-6673 or email: [dcamp@utah.gov](mailto:dcamp@utah.gov)

Reference number issued by Dan Camp: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

When requesting equipment, please include the following:

- a) A description of the current system (including diagrams).
- b) The proposed change (including diagrams).
- c) The reason for the proposed change.
- d) Percentage of time equipment will be used for EMS purposes.
- e) When requesting pagers, the applicaion shall state the number of functional pagers, the number of personnel who carry pagers and the numbe of personnel per unit.
- f) Date contact was made with Dan Camp.

**MEDICAL EQUIPMENT GRANT JUSTIFICATION FY2016 - Category 4**  
**Bureau of Emergency Medical Services and Preparedness**  
**This form should be computer generated or typed**

**Agency Information:**

Name of agency: \_\_\_\_\_ EMS Provider No. \_\_\_\_\_  
 Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
 City: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Agency Telephone No. \_\_\_\_\_

Items Requested:	Units	Price	Total	Local Match	State Share

JUSTIFICATION: When requesting equipment, a copy of the vendor equipment information about the item must be attached to application.

JUSTIFICATION:

**VEHICLE GRANT JUSTIFICATION FY2016 - Category 5**  
**Bureau of Emergency Medical Services and Preparedness**  
**This form should be computer generated or typed**

**Agency Information:**

Name of agency: \_\_\_\_\_ EMS Provider No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ DUNS No. \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Telephone No. \_\_\_\_\_

Vehicles Requested:	Units	Price	Total	Local Match	State Share

Purpose:

- Additional Vehicle
- Replacement Vehicle
- Remount Vehicle

If a replacement vehicle, which vehicle will it replace:

What will be the disposition of the vehicle being replaced:

**JUSTIFICATION:**

(The Vehicle Inventory sheet must also be completed by the applicant.)

**EMERGENCY VEHICLE INVENTORY FY2016 - Category 5**

**Bureau of Emergency Medical Services and Preparedness**

**This form should be computer generated or typed**

**Name of Agency:** \_\_\_\_\_

Type of Vehicle: \_\_\_\_\_ Make: \_\_\_\_\_  
Age of vehicle: \_\_\_\_\_ Mileage: \_\_\_\_\_  
Expenses during past year. \_\_\_\_\_  
General Condition: \_\_\_\_\_

Type of Vehicle: \_\_\_\_\_ Make: \_\_\_\_\_  
Age of vehicle: \_\_\_\_\_ Mileage: \_\_\_\_\_  
Expenses during past year. \_\_\_\_\_  
General Condition: \_\_\_\_\_

Type of Vehicle: \_\_\_\_\_ Make: \_\_\_\_\_  
Age of vehicle: \_\_\_\_\_ Mileage: \_\_\_\_\_  
Expenses during past year. \_\_\_\_\_  
General Condition: \_\_\_\_\_

Type of Vehicle: \_\_\_\_\_ Make: \_\_\_\_\_  
Age of vehicle: \_\_\_\_\_ Mileage: \_\_\_\_\_  
Expenses during past year. \_\_\_\_\_  
General Condition: \_\_\_\_\_

*Use additional sheets if necessary.*

**INITIAL TRAINING AND CONTINUING MEDICAL EDUCATION GRANT JUSTIFICATION FY2016 - Category 6  
Bureau of Emergency Medical Services and Preparedness**

**This form should be computer generated or typed**

**Non EMS licensed agencies are eligible for initial dispatch and EMT training only**

(This category counts as one item)

**Agency Information:**

Name of agency:	_____	EMS Provider No.	_____
Address:	_____	DUNS No.	_____
City:	_____	County:	_____
Zip Code:	_____	Contact Person:	_____
		Email:	_____
		Telephone No.	_____

	Requested	Amount
1.		
2.		
3.		
4.		
		\$

Line Number 1 is for agency request with State share up to \$4,500. Lines 2-4 are for additional service area requests. Lines 2-4 may not exceed \$3,000 State share.

If additional service areas are requested, separate justification must include what cities are serviced and **a roster for each service area must be submitted.** The roster can also be used for per capita rosters. (Refer to page 3 of the Competitive Guidelines.)

Number	Level of Personnel
	Dispatchers
	Emergency Medical Responders
	EMT
	AEMT
	Paramedic

JUSTIFICATION: (use additional sheets if necessary)

Proposed CME plan

Plan Cost:

\$
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Proposed Initial Training Plan:

Levels to be trained:

\$
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