NEW MEXICO DEPARTMENT OF HEALTH

EMS FUND ACT
STATEWIDE SYSTEM IMPROVEMENT PROJECT
APPLICATION FOR FISCAL YEAR 2021

Due Date: November 15, 2019
Applications must be typed – handwritten and/or incomplete applications will be rejected

FOR BUREAU USE ONLY (do not write in this area)		
Date Received	**Region**	**Reviewer**

Name of Applicant ➔ *(EMS Service/Agency)*	

Address ➔	

Contact Person ➔		
Telephone #	Fax #	Email

Fiscal Agent ➔ *(County or Municipality)*	

Address ➔	

Contact Person ➔		
Telephone #	Fax #	Email

Name(s) of other EMS Service(s) and/or communities involved in this project:	

A. Detailed Analysis of Problem and Need:

Using only the space below, describe the proposed project. Include at least 5 points as to how this project will contribute to and/or improve the EMS System in New Mexico. (D*o not attach additional sheets)*

B. Service Area Description:

Using only the space below, describe in your application how this project will demonstrate cooperation and collaboration between at least two EMS systems, counties, training institutions, an EMS Regional office or the EMS Bureau. Information should include a complete service area description, organization of the system and which services are involved (responding units, rescues, ambulances, hospital, municipalities, counties, schools, regional offices, etc.). *(Do not attach additional sheets)*

C. Project Impact:

Using only the space below, describe how your proposal or project will impact the Statewide EMS System and the residents of New Mexico. Describe how this project will strengthen relationships/partnerships (private and public entities) around EMS and Health Communities. ***(Do not attach additional sheets)***

D. Cost of Project:

Item Description	Quantity	Unit Cost	Total Cost
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
			$ 0.00
PROJECT COST SUBTOTAL:			$ 0.00
Matching contribution provided by recipient/applicant (Not Required)			
- **Financial Contribution total**			
- **Financial Contribution Source(s)**			
In kind contribution description			**Value**
Total matching contribution			$ 0.00
Total amount requested from Fund Act			$ 0.00

*1. Applicant must provide an itemized report of monetary contributions to include amount, source and any special considerations.

*2. Applicant must provide quotes of items that are being purchased for this project. Please attach to application.

E. Letters of Collaboration/Support:

Letters of collaboration between the primary entities are required for this application. Additionally, support from other services, entities, and stakeholders greatly strengthen the application. Each service's, entities, or stakeholder's support should be expressed in **3 or more separate letters.** **NO DUPLICATES.**

All letters of collaboration and letters of support must be included with this application.
Letters will not be accepted once the application is submitted.

F. Accountability of Previously Funded Special Project:

Have any of the collaborating entities been awarded special funding (i.e., Trauma Systems, Vehicle, Local or Statewide) within the last 5 years? Please describe the status/outcome of the funded project/vehicle.
Failure to accurately disclose this information will disqualify the application.

FY of Award	Amount	Name of Project/Description	Status

G. Project Information

1. Have you **secured** any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
2. Have you **applied** for any additional funding for this project?	☐ **Yes** ☐ **No**
If "Yes", please list source and amount:	
3. Can this project be phased?	☐ **Yes** ☐ **No**
4. Will phasing the project allow for each phase to allow for an independently functional component?	☐ **Yes** ☐ **No**

5. If the project is for training, please describe the strategy you will utilize to recruit attendees:
☐ N/A

ASSURANCES

The following are required assurances associated with your EMS Statewide System Improvement Project for Fiscal Year _____.

- I certify that funds received through this distribution will be used only for the purposes and under the condition expressed in the application or its approved amendment(s);
- I certify that we will provide the support and involvement either cash and/or in-kind contributions as described in this application;
- I certify that we understand and agree to comply with all applicable requirements of the New Mexico Department of Health; and
- I certify that the information contained in this application is true and correct to the best of my knowledge.

Chief / Director of Local EMS Service or (Project Manager of Agency if Non-Profit Group/Training Institution)

NAME: _____ TITLE: _____
(Print / Type Name)

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ of _____, 20___
(Day) (Month)

_____
Notary Public

My commission expires: _____

(SEAL)

Mayor / Chairman County Commission or (Director of Agency if Non-Profit Group/Training Institution)

NAME: _____ TITLE: _____
(Print / Type Name)

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ of _____, 20___
(Day) (Month)

_____
Notary Public

My commission expires: _____

(SEAL)

Regional Office and Service Checklist

		Region Initial		Service Initial	
1.	All signatures on proper signature lines				
2.	All applicable financial quotes attached				
3.	All Letters of Collaboration and Support				
4.	All Notary signatures in proper place				
5.	All detailed contributions listed				
6.	All benefiting services or counties listed				
7.	Letter and approval of extension if needed				
8.	Fiscal agent's correct mailing address				
9.	Recipient's correct mailing address				
10.	Original and 2 Copies-No special binding.				

Regional Office Reviewer

NAME: _____ TITLE: _____

(Print / Type Name)

SIGNATURE: _____ DATE: _____