NEW MEXICO DEPARTMENT OF HEALTH

EMS FUND ACT
STATEWIDE SYSTEM IMPROVEMENT PROJECT
APPLICATION FOR FISCAL YEAR 2019

Due Date: November 17, 2017

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

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: **Describe, in detail the proposed project. Include a detailed analysis of the need and a narrative showing how this project will contribute to and/or improve EMS System in New Mexico. (Attach additional sheets if necessary)**

B. Service Area Description: **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, and how the proposal may be justified as being a "Statewide" project. 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.). Provide as much detail as possible regarding your current system. (Attach additional sheets if necessary)**

C. Project Impact: **Clearly identify, in detail, 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. (Attach additional sheets if necessary)**

D. Cost of Project:

Project Components/ Description	

Total Cost of Project (Please provide an Itemized Estimate) *1	
Monetary Contribution from Recipient/Applicant *2	
Amount Requested from **Fund Act**	

*1. Applicant must provide an itemized expense report/estimate for complete project

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

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 letter.** **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, unless prior approved

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 3 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

ASSURANCES

The following are required assurances associated with your EMS Statewide System Improvement Project for Fiscal Year 2017.

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

SIGNATURE: _____ DATE: _____

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

_____ -
Notary Public

My commission expires: _____

(SEAL)

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

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

SIGNATURE: _____ DATE: _____

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

_____ -
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: _____