



**Criticality of the Ambulance Service (Pass or Fail)**

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 5)* for detailed information regarding the completion of this section.

## Financial Need (15 Points)

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 4)* for detailed information regarding the completion of this section.

### Financial Information Form

Ambulance Service					
Funding Area Number					
1. Please enter fiscal year end date					
Cash in Bank			\$		
Other Financial Assets			\$		
2. Total Value of Cash in Bank and Other Financial Assets			\$		
3. Unpaid Accounts Receivable Invoiced/Billed Within 12 Month Period			\$		
4. Equipment					
	Vehicle	Year	Vehicle Cost	Cost of Equipment Added to Vehicle	Mileage
Do you own or rent your building(s)?		<input type="checkbox"/> Own	<input type="checkbox"/> Rent	<input type="checkbox"/> N/A	
If you own your buildings, what is the value of the building(s)?			\$		
5. Accounts Payable			\$		
List those bills that are 30 days past due					
	Bill	Date of Bill	Amount Owed		

List those bills that are 30 days past due (continued)		
Bill	Date of Bill	Amount Owed

6. List of outstanding loans				
Purpose of Loan	Payoff Amount	Monthly Payment	Number of Remaining Payments	Loan End Date

7. Annual Revenue	
Ambulance Service Fees	\$
Donations/Fundraisers	\$
Grants	\$
Mill Levy	\$
Tax Based Revenue	\$
Interest Income	\$
All Other Income	\$
Total Annual Revenue	\$

8. Annual Expenses	
Permanent Staffing	\$
Volunteer Staffing	\$
Payroll Taxes <sup>1</sup>	\$

8. Expenses (continued)		
	Telephone	\$
	Billing Service Fees <sup>2</sup>	\$
	Interest Expense	\$
	Office Supplies	\$
	Repairs	\$
	Insurance <sup>3</sup>	\$
	Legal & Other Professional Fees	\$
	Fuel	\$
	Facility Rent Expense	\$
	Utilities <sup>4</sup>	\$
	Medical Supplies	\$
	Bad Debt Expense <sup>5</sup>	\$
	All Other Expenses (Please List)	
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
	Total Annual Operating Expenses	\$
	Revenues Less Expenses	\$
9. Have you foregone any expenses because of funding shortages? (please list)		
	1.	
	2.	
	3.	

## **EMS System Integration Development and Justification (Pass or Fail)**

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 5)* for detailed information regarding the completion of this section.

### **Strategic Planning (20 Points)**

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 6)* for detailed information regarding the completion of this section.

**Quality Improvement (20 Points)**

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 6)* for detailed information regarding the completion of this section.



**Project Budget Itemization**

Refer to the *North Dakota Rural EMS Assistance Fund Grant Guidance - Part II (page 6)* for detailed information regarding the completion of this section.

Personnel/Staffing	
Travel, Food and Lodging	
Supplies	
Rent/Utilities	
Communications (Telephone/Postage)	
Equipment	
Consultant/Contractual	
Other/Optional	
Other/Optional	
Other/Optional	
Other/Optional	
Other/Optional	
Other/Optional	

**Project Budget Justification**

Using budgeted numbers, briefly describe in detail how monies will be spent in each category of the proposed budget.

## Signature Block

The name of service and signature of an authorized representative (squad leader / board chair) of each involved entity/service is required in order for this application to be considered complete. Signature in this block verifies agreement of all arrangements/project efforts established in this grant application.

Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date

## Refusal Signature Block

The name of service and signature of an authorized representative (squad leader / board chair) of each entity/service refusing to participate in grant planning is required in order for this application to be considered complete. Signature in this block verifies that each entity/service has been given the opportunity to participate in this grant planning and has willingly opted out. Run volume for entities/services not participating will not be taken into consideration for funding awards.

Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date
Signature of Squad Leader	Name of Squad	Date

## Signature of Authorized Representative

As the person completing this application, I certify that the information contained within is true and correct to the best of my knowledge. I also acknowledge that any funds received from this grant will be expended according to the laws of the State of North Dakota for the purpose stated in this application.

Signature of Authorized Representative	Date
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Submit completed application and accompanying documents to:



North Dakota Department of Health  
Division of Emergency Medical Systems  
1720 Burlington Drive  
Bismarck, ND 58504

**All applications must be postmarked no later than 5 p.m. on October 27, 2017. Any applications received after this deadline will not be accepted. A confirmation e-mail will be sent upon receipt of this application.**