



**NORTH DAKOTA RURAL EMS ASSISTANCE FUND**  
**BUDGET INFORMATION FORM**  
NORTH DAKOTA DEPARTMENT OF HEALTH  
DIVISION OF EMERGENCY MEDICAL SYSTEMS  
(8-2018)



This completed budget information form and any accompanying documents must be submitted to the Department of Health prior to requesting reimbursement payments from REMSA Part III Funding. You may attach additional pages if necessary.

This information will be compiled and broken down in order for the Department to gain a clearer financial picture of EMS in North Dakota. This information will then replace the estimated model budgets used in future grant funding formulas. Individual service budgets will not be shared.

Ambulance Service	Date
Physical Address	
City	ZIP Code
Contact Person/Representative	
Email Address	Daytime Telephone Number
1. Fiscal year end date	
2. Annual Revenue	
Ambulance Service Fees	\$
Donations/Fundraisers	\$
Grants	\$
Mill Levy	\$
Tax Based Revenue (From county or city)	\$
Interest Income	\$
All Other Income	\$
Total Annual Revenue	\$
3. Annual Expenses	
Personnel/Staffing (Including wages, benefits and payroll taxes)	\$
Staff Education (Including conferences, conventions and related travel)	\$
Professional Fees (Billing/claims, mgmt, consultant/contractual, legal, accounting, fundraising, etc.)	\$
Advertising	\$
Office Expense	\$
Interest Expense	\$
Communications/IT (Dispatch, internet, telephone, computer and related expenses)	\$

### 3. Annual Expenses (continued)

Occupancy (Mortgage, rent, utilities, real estate taxes, building repair & maintenance, etc.)	\$
Ambulance Repair and Maintenance	\$
Ambulance/Medical Supplies	\$
Fuel	\$
Equipment	\$
Equipment Repair and Maintenance	\$
Depreciation	\$
Bad Debt Expense	\$
All Other Expenses (Please List)	

	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$

Total Annual Operating Expenses	\$
Revenues Less Expenses	\$

### 4. Have you foregone any expenses because of funding shortages? (please list)

1.
2.
3.

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 form to:



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