

*2021 BROWARD COUNTY EMS GRANT APPLICATION*  
*"Funding to improve or expand prehospital EMS Systems"*

**Section I**

1. **Project Title:** \_\_\_\_\_

Is this a pilot project?       Yes    No

2. **Project Cost \$:** \_\_\_\_\_

3. **Agency Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_      Fax: \_\_\_\_\_

4. **Project Manager:** The individual with direct knowledge of project and responsible for project implementation.

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_      Email: \_\_\_\_\_

5. **Authorized Signatory:** The individual authorized to sign the application on behalf of the agency or entity.

Name of Signatory: \_\_\_\_\_

Title of Signatory: \_\_\_\_\_

6. **Projects Impacting Direct Services to Emergency Victims:** This may include, but is not limited to: vehicles, medical and rescue equipment, communications, dispatch, navigation, and other equipment that impacts on-site treatment. (Countywide projects must offer participation to all licensed EMS providers, based upon levels of service.) Attach Form A.

Countywide:       Yes       No

Multiple Agencies:  Yes       No      How Many? \_\_\_\_\_

Single Agency:       Yes       No

7. **Projects Impacting Indirect Services:** Training of all types (public, first responders, law enforcement personnel, EMS personnel and other healthcare staff), research, and documentation. (Countywide projects must offer participation to all licensed EMS providers.) Attach Form A.

Countywide:       Yes       No

Multiple Agencies:  Yes       No      How Many? \_\_\_\_\_

Single Agency:       Yes       No

*2021 BROWARD COUNTY EMS GRANT APPLICATION*

*"Funding to improve or expand prehospital EMS Systems"*

**8. Problem/Unmet Need Description:** Provide a narrative of the problem or need and the population affected by describing the present situation and management (if any) and the potential adverse consequences if not addressed.

*2021 BROWARD COUNTY EMS GRANT APPLICATION*

*“Funding to improve or expand prehospital EMS Systems”*

**9. EMS Improvement and Expansion to Resolve Problem or Address Needs:**

Describe proposed solutions to the problem and/or need (question #8 – problem description). State the improvements that are reasonably foreseeable and measurable. Use data, scientific, or anecdotal information to support the agency's request. Explain how the project will improve and/or expand prehospital EMS in Broward County. Be specific.

*2021 BROWARD COUNTY EMS GRANT APPLICATION*

*"Funding to improve or expand prehospital EMS Systems"*

<b>10. Measurable Outcomes:</b> Outcomes should be viewed from the perspective of the project and provide for: improved conditions/service - for patients as well as EMS personnel; expanded services; new knowledge; or improved knowledge. <b>Outcomes must be measurable and attainable. (Attach additional pages, as needed.)</b>	
<b>A. Project</b>	
<b>B. Activities</b>	
<b>C. Outcomes</b>	
<b>D. Indicators</b>	
<b>E. Data Source</b>	
<b>F. Data Collection Method</b>	

*2021 BROWARD COUNTY EMS GRANT APPLICATION*  
*“Funding to improve or expand prehospital EMS Systems”*

**11. Project Schedule:** Please complete the table below. Insert additional rows if needed.

Months after Grant is Executed	Activity

**12. Supporting Research or Literature?**  Yes (Attachment A)  No  
 (Required if this is a Pilot Project.)

**13. Letters of Support or Reference?**  Yes (Attachment B)  No

**14. Budget:** Do not use brand names when listing items. Use only generic names. Round up/down to the nearest dollar. Please use the table below. Insert additional rows if needed. Do not include extended warranties.

Item	Unit Cost	Quantity	Total
Delivery charges, if any			
Total			\$

**15. Future Expenses:** Estimate the maintenance or other required recurring expenses per unit after the first grant year (if applicable). Note: No funding will be provided for these expenses under this grant program and must be absorbed by the grant recipient(s). Discuss this issue with your agency as it may affect its budget.

Items	Cost

**Grant monies cannot be used to replace existing equipment.**

\_\_\_\_\_  
 Initials of authorized signatory acknowledging the individual understands this statement.

*2021 BROWARD COUNTY EMS GRANT APPLICATION*

*"Funding to improve or expand prehospital EMS Systems"*

- 16. Medical Director Approval:** For all projects requiring approval from the agency's Medical Director in accordance with Chapter 401, Florida Statutes, or Chapter 64J-1, Florida Administrative Code.

**The undersigned, as Medical Director for this agency, supports and approves this project.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

- 17. Partial Funding:** Will the agency accept partial funding?  
(Note: If the agency is awarded partial funding, an amendment to the outcomes and budget forms must be submitted).

Yes, the agency will accept partial funding

No, the agency will not accept partial funding

Signature: \_\_\_\_\_  
(Authorized Signatory)

Printed Name: \_\_\_\_\_

**AGENCY NAME:** \_\_\_\_\_

**AUTHORIZED SIGNATORY:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PRINT AUTHORIZED SIGNATORY NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**PROJECT MANAGER'S SIGNATURE:** \_\_\_\_\_

**PRINT PROJECT MANAGER'S NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

*2021 BROWARD COUNTY EMS GRANT APPLICATION*  
*“Funding to improve or expand prehospital EMS Systems”*

**If this is a Single Agency Project, this is the last page of the application.**

**If this is a Multiple Agency/Countywide Project (excluding Countywide training projects), please continue by completing the Participating Agency Summary Sheet (Form A) and Section II for each Participating Agency.**

**Grant Application Submission Deadline:**

**Tuesday, September 15, 2020 at 2 p.m.**

**\*\*\*\*\* Remainder of Page Intentionally Left Blank \*\*\*\*\***





*2021 BROWARD COUNTY EMS GRANT APPLICATION*  
*“Funding to improve or expand prehospital EMS Systems”*

**SECTION II**  
**(Complete for ALL “Multiple Agencies” or “Countywide” Projects,**  
**EXCLUDING Countywide Training Projects)**

**Does your agency desire to participate in the grant project?**

If No, ignore the remaining questions and return the form to the Project Manager (GRANTEE).

\_\_\_\_\_  
**Initials of authorized signatory for Participating Agency**

If Yes, complete remaining items and return to:

Project Manager (name) \_\_\_\_\_

The undersigned Participating Agency \_\_\_\_\_

(Agency name)

agrees to enter into an ADDENDUM TO BROWARD COUNTY EMS GRANT FUNDING AGREEMENT and acknowledges that it has joined in with the

\_\_\_\_\_ (GRANTEE) on a Project Application for

(Project Title and Summary) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

as part of the BROWARD COUNTY EMS GRANT FUNDING. The Participating Agency acknowledges that, to be included as a Participating Agency under the agreement between BROWARD COUNTY and GRANTEE for BROWARD COUNTY EMS GRANT FUNDING (“Agreement”), it will be required to agree to the terms and conditions for the funding.

**1. Medical Director Approval:**

For projects requiring approval from the agency's Medical Director in accordance with Chapter 401, Florida Statutes, or Chapter 64J-1, Florida Administrative Code, the agency's Medical Director must complete the following:

**As Medical Director for above Participating Agency, I support and approve this project.**

**AUTHORIZED SIGNATURE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

*2021 BROWARD COUNTY EMS GRANT APPLICATION*

*"Funding to improve or expand prehospital EMS Systems"*

**2. Recurring Expenses after the grant year:**

The estimate for maintenance or other required expenses per unit after the first grant year, if applicable, are listed below. These costs will be absorbed by the grant recipient(s) (including each Participating Agency) and not paid from grant funds.

Item \_\_\_\_\_ Cost \$ \_\_\_\_\_

\_\_\_\_\_ Initials of authorized signatory for \_\_\_\_\_  
(Participating Agency)

**3. State the number of items requested or Training Participants. \_\_\_\_\_**

**4. PARTICIPATING AGENCY AUTHORIZED SIGNATORY:**

\_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**5. PARTICIPATING AGENCY PROJECT LEADER SIGNATURE:**

\_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**PARTICIPATING AGENCY PROJECT LEADER TITLE:**

\_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**6. PROJECT MANAGER (GRANTEE'S RESPONSIBLE AGENT) SIGNATURE:**

\_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**PROJECT MANAGER TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **TELEPHONE:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

## FY 2021 Budget

Airway Equipment	\$5,454
Airway Training	\$64,546
<b>TOTAL</b>	<b>\$70,000</b>

## Advanced Airway Class by Agency

<b>Durable Equipment and Airway Class</b>	<b>Number</b>	<b>Cost per unit</b>	<b>Total</b>
AirTrac Video Laryngoscope	1	\$700	\$700
King Vision Video Laryngoscope	1	\$1,000	\$1,000
Life/Form "Airway Larry" Adult Head	1	\$800	\$800
Trucorp AirSim Combo X Difficult Airway Trainer	1	\$2,154	\$2,154
Silicone Skin Materials (Cric Training Supplies)	2	\$400	\$800
Airway Class	306	\$211	\$64,546
Airway Allowance per Agency	17	-	-
<b>TOTAL</b>	-	-	<b>\$70,000</b>