2025 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: ☐

Multiple Agencies: ☐ How Many? ____

Single Agency: ☐

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: ☐

Multiple Agencies: ☐ How Many? ____

Single Agency: ☐

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.

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.

10. Measurable Outcomes: 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. **Outcomes must be measurable and attainable. (Attach additional pages, as needed.)**	
A. Project	
B. Activities	
C. Outcomes	
D. Indicators	
E. Data Source	
F. Data Collection Method	

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
None	

Grant monies cannot be used to replace existing equipment.

_____
Initials of authorized signatory acknowledging the individual understands this statement.

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: _____

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, November 26, 2024 @ 3:00 PM

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Form A

Participating Agency Summary Sheet
(Attach a copy of negative responses)

Agency Name	Not Interested	No Response	Quantity Requested
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
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	☐	☐	
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	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

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:** _____

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: _____