

## **Instructions: County Government Application Form 2021-2022**

The first application page has five numbered items.

Please note that **Item 2** on the first application page is where the county's authorized person must provide his/her signature and date.

Item 4 describes the content of the current “resolution” that is required. However, if a previous resolution has continuing authority, include a signed message stating such and provide a copy of the previous resolution.

Item 5 of the first page of the application form asks for the name of the organization(s) to which you decide to allocate funds from your new county grant. The second page of the application form is the budget page. One of these budget pages is needed for each organization listed in item 5.

The county alone has the authority to use all of the grant funds itself or to provide some of the funds to other organizations within the county. However, the county remains responsible to the state for all funds.

The budget costs must total the exact amount of new funds for your grant. You can request budget changes and add to the new grant budget unexpended funds from the prior grant after the new grant begins.

The Request for Grant Fund Distribution Form is the last page herein and you must complete only the top part of the form. State EMS will complete the bottom part, as stated on the form.

You should copy all forms on your computer to use them. If you place them in restricted editing mode, you can use your keyboard Tab key to go from field to field.

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**EMS COUNTY GRANT APPLICATION**

**FLORIDA DEPARTMENT OF HEALTH  
Emergency Medical Services Program  
Complete all items**

**ID. Code (The State EMS Program will assign the ID Code – leave this blank) \_\_\_\_\_**

|   |
|---|
| <b>1. County Name:</b>                        |
| Business Address:                             |
|   |
|   |
| Telephone:                                    |
| Federal Tax ID Number (Nine Digit Number): VF |

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|--|
| <b>2. Certification:</b> (The applicant signatory who has authority to sign contracts, grants, and other legal documents for the county) I certify that all information and data in this EMS county grant application and its attachments are true and correct. My signature acknowledges and assures that the county shall comply fully with the conditions outlined in the Florida EMS County Grant Application.<br><b>Signature:</b> _____ <b>Date:</b> _____ |
| Printed Name:  |
| Position Title:  |

|  |
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| <b>3. Contact Person:</b> (The individual with direct knowledge of the project on a day-to-day basis and has responsibility for the implementation of the grant activities. This person is authorized to sign project reports and may request project changes. The signer and the contact person may be the same.) |
| Name:  |
| Position Title:  |
| Address:   |
|  |
|  |
| Telephone: _____ Fax Number: _____   |
| Email Address:   |

**4. Resolution:** Attach a resolution from the Board of County Commissioners certifying the grant funds will improve and expand the county pre-hospital EMS system and will not be used to supplant current levels of county expenditures. We cannot process for funds without this resolution.

|  |
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| <b>5. Organization List:</b> Complete a budget page(s) for each organization, which at your option you will provide funds. List the organization(s) below. (Use additional pages if necessary) |
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|  |
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|  |
|  |



**FLORIDA DEPARTMENT OF HEALTH  
EMERGENCY MEDICAL SERVICES (EMS) GRANT UNIT**

**REQUEST FOR GRANT FUND DISTRIBUTION**

In accordance with the provisions of section 401.113(2) (a), *Florida Statutes*, the undersigned hereby requests an EMS grant fund distribution for the improvement and expansion of pre-hospital EMS.

**DOH Remit Payment To:**

The county name, address, and corresponding federal ID number **must** be in the state MyFloridaMarketPlace (MFMP) system. A finance person in your organization who does business with the state must provide these.

Name of County: \_\_\_\_\_

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

Federal 9-digit Identification number: \_\_\_\_\_ 3-digit seq. code

Authorized County Official: \_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Type or Print Name and Title

*Sign and return this page with your application to:*

*Florida Department of Health  
Emergency Medical Services Unit, Grants  
4052 Bald Cypress Way, Bin A-22  
Tallahassee, Florida 32399-1722*

**Do not write below this line. For use by State Emergency Medical Services Section**

Grant Amount for State to Pay: \$ \_\_\_\_\_ Grant ID: Code: \_\_\_\_\_

Approved By: \_\_\_\_\_  
Signature of State EMS Unit Supervisor Date

Approved By: \_\_\_\_\_  
Signature of Contract Manager Date

State Fiscal Year: \_\_\_\_\_ 2021 - 2022 \_\_\_\_\_

| <u>Organization Code</u> | <u>E.O.</u> | <u>OCA</u> | <u>Object Code</u> | <u>Category</u> |
|--------------------------|-------------|------------|--------------------|-----------------|
| 64-61-70-30-000          | 05          | SF005      | 751000             | 059998          |

Federal Tax ID: VF \_\_\_\_\_ Seq. Code: \_\_\_\_\_

Grant Beginning Date: \_\_\_\_\_ Grant Ending Date: \_\_\_\_\_