



EMS COUNTY GRANT APPLICATION 2022 - 2023

**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) _____

1. County Name:	Hernando County Board of County Commissioners
Business Address:	15470 Flight Path Drive Brooksville, FL 34604
Telephone:	352-540-4353
Federal Tax ID Number (Nine Digit Number):	VF 59-1155275

2. Certification: (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.

Signature:	Date:
Printed Name: Steve Champion	
Position Title: Chairman, Board of County Commissioners	

3. Contact Person: (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:	Marie Austin
Position Title:	Finance Specialist
Address:	15470 Flight Path Drive Brooksville, FL 34604
Telephone:	352-540-4353
Fax Number:	
E-mail Address:	maustin@hernandocounty.us

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.

5. Organization List: 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)

Hernando County Fire and Emergency Services	\$19,334

BUDGET PAGE - When the budget form is in your computer, the budget totals below should be added for you if you place your cursor over a subtotal or total field, right click your mouse, then left click "Update Field" on the resulting menu.

A. Salaries and Benefits:

For each position title, provide the amount of salary per hour, FICA per hour, other fringe benefits, and the total number of hours.	Amount
TOTAL Salaries =	\$ 0.00
TOTAL FICA & Other Benefits =	
Total Salaries & Benefits =	\$ 0.00

B. Expenses: These are travel costs and the usual, ordinary, and incidental expenditures by an agency, such as, commodities and supplies of a consumable nature excluding expenditures classified as operating capital outlay (see next category).

List the item and, if applicable, the quantity	Amount
King Vision aBlade Laryngoscope Kit - Adult - Qty: 3	\$4,459.35
King Vision aBlade Laryngoscope Kit - Pediatric - Qty: 3	\$2,024.82
Stair Chairs - Qty: 3	\$11,020.83
Handteavy Pediatric Bags - Qty: 3	\$ 1,512.31
Total Expenses =	\$19,017.31

C. Vehicles, equipment, and other operating capital outlay means equipment, fixtures, and other tangible personal property of a non-consumable and non-expendable nature with a normal expected life of one (1) year or more.

List the item and, if applicable, the quantity	Amount
Total Vehicles & Equipment =	\$ 0.00
<u>Grand Total =</u>	<u>\$ 0.00</u>

**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 used herein must be in the state MyFloridaMarketPlace (MFMP) system. A finance person in your organization who does business with the state can provide these.

Name of County: Hernando County Board of County Commissioners

Mailing Address: 15470 Flight Path Drive

Brooksville, FL 34604

Federal 9-digit Identification number: 59-1155275 3-digit seq. code _____

Authorized County Official: _____ Date _____

Signature

Date

Steve Champion, Chairman

Type or Print Name and Title

**APPROVED AS TO FORM
AND LEGAL SUFFICIENCY**

BY [Signature]
County Attorney's Office

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: 2022 - 2023

<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: _____