Instructions: County Government Application Form 2023-2024

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 the 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 about this 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, and one of these budget pages is needed for each organization listed in Item 5.

The county alone has the authority to use all 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 the funds.

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

Note: This instruction form is for information purposes only and is not part of form DH 1684.

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) _____

1. County Name: **Hernando County**
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: Elizabeth Nar **Date:** 12/12/23
Printed Name: Elizabeth Narverud
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: **Kelly Trout**
Position Title: **Finance Manager**
Address: **15470 Flight Path Drive**
Brooksville FL 34604

Telephone: **352-540-4353**	Fax Number:
E-mail Address: **ktrout@co.hernando.fl.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 Rescue - $20,625.00

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**
Total Expenses =	**$ 0.00**

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**
11 CR2 AEDs including cases ($1,875.00 each)	**20,625.00**
Total Vehicles & Equipment =	**$ 20,625.00**
Grand Total =	**$ 20,625.00**

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**

Mailing Address: **15470 Flight Path Drive**

Brooksville, FL 34604

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

Authorized County Official: _____ **12/12/2023**
Signature **Date**

Elizabeth Narverud
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: 2023 - 2024

Organization Code	E.O.	OCA	Object Code	Category
64-61-70-30-000	05	SF005	751000	059998

Federal Tax ID: VF _____ Seq. Code: _____

Grant Beginning Date: _____ Grant Ending Date: _____