FY 2019
Idaho Emergency Medical Services (EMS) Account III Grant Application

IMPORTANT INSTRUCTIONS FOR SUBMITTING YOUR APPLICATION

Your submitted application is FINAL and only ONE application will be accepted. There are no courtesy reviews of applications; if you have questions, contact the Bureau of EMS and Preparedness PRIOR to submitting your application. The required attachments (fleet report, vendor quotes, W-9, etc.) are considered an integral part of the application. Therefore, any omissions or errors will cause the application to be incomplete.

The Bureau conducts a Grant Application webinar each year to help you complete the application. It is strongly recommended that you attend this webinar as it will likely answer many of the questions you may have. The webinar is recorded, so if you cannot attend live, it may be watched later. The FY2019 webinar is scheduled for March 21. Registration is open now on the grants page of the EMS website at www. idahoems.org.

If you are applying for an EMS Vehicle you will need to request a Vehicle Fleet Report from the Bureau. Verify and update the information in this report. This information will be used when processing your application and also to update your agency's licensure file. You may make handwritten notations to update the report but, be sure they are legible.

The grant application is a fillable Adobe document that can be completed using Adobe Reader (www.adobe. com/downloads/). You can verify receipt of the application on the Grant web page at www.idahoems.org.

Application Due: On or before May 31, 2018

	Email - Preferred method	In Person	Mail	Fax
Submission Methods	emsgrants@dhw.idaho.gov	2224 Old Penitentiary Rd Boise, ID 83712	Bureau of EMS & Preparedness PO Box 83720 Boise, ID 83720-0036	208-334-4015
	Send deadline: 11:59 p.m. May 31, 2018	Close of Business 5:00 p.m. May 31, 2018	Postmarked: May 31, 2018	Send deadline: 11:59 p.m. May 31,2018

For Bureau Use Only

Date Received by BUREAU OF EMS & PREPAREDNESS
Method of Receipt:

___ Email_____Fax_____In Person_____Mail

Date Postmarked: _____

Date & time faxed or e-mailed:_____

Date & time delivered to EMS Bureau: _____

Adobe Acrobat Reader DC Download

Submit by E-mail
(Remember Attachments)

Section F. Required Attachment Checklist

The following documents are attached to this application.
(Check applicable boxes)

☐ 1. County or incorporated city government (in your primary response area) **endorsements.**

☐ 2. Documentation of one (1) or more **vendor price quotes** for all proposed vehicle/equipment purchases.

☐ 3. If requesting a new vehicle to replace an old vehicle, attach a copy of the **old vehicle's title or registration.**

☐ 4. If requesting a vehicle, contact the EMS Bureau for an **Agency Vehicle Fleet Report**. Update the fleet report and return with your application.

☐ 5. If requesting **extrication equipment**, provide a list of all personnel trained at the Extrication Operations level.

☐ 6. Completed and **signed W-9** to assist the Bureau in processing your award.

☐ 7. CONDITIONAL: Medical Director Endorsement (enclosed)

Quick Submit by E-mail
(Remember Attachments)

FY2019 EMS ACCOUNT III GRANT FUND APPLICATION

56-1018B. EMERGENCY MEDICAL SERVICES FUND III. (1) There is hereby created in the dedicated fund of the state treasury a fund known as the emergency medical services fund III. Subject to appropriation by the legislature, moneys in the fund shall be used exclusively for the purpose of acquiring vehicles and equipment for use by emergency medical services personnel in the performance of their duties which include highway safety and emergency response to motor vehicle accidents.

SECTION A: Agency/Financial/Demographic Information

1. GENERAL INFORMATION

Agency Name *(As it appears on license)* _____

Agency License # _____ Federal Tax ID# _____

Agency Type:

Registry No. Secretary of State
(Required for non-profit status) _____

Name of Person Completing Application: _____

Daytime Phone # _____ Email _____

Number of licensed Volunteer Providers

Number of licensed Career Providers

2. DEMOGRAPHIC

Call Volume for Calendar Year 2017 *(Idaho EMS responses only)* _____

Number of **full time** residents within your primary response area in Idaho _____

Attach county and/or city government endorsements.

Acceptable endorsements may be from:

- *County commissioners or incorporated city government officials (mayor, city manager, council members) within your agency's primary Idaho response area.*
- *One of the above endorsements must be the vehicle title holder if you are requesting a vehicle.*
- *If there are multiple incorporated cities and/or counties in your primary Idaho response area, include endorsements from each.*
- *Note that multiple endorsements from the same entity (i.e. multiple county commissioners from the same county) will only count as a single endorsement.*
- *Endorsements from taxing districts are not acceptable.*

If applying for a vehicle, the name of the incorporated city or county to be the title holder.
(as described above - cannot be the applying agency) _____

3. FINANCIAL/OPERATING INFORMATION

Provide financial operating information for one full fiscal year. This should be the most recent completed fiscal year data. Do not leave any blanks. Enter "0" if none.

Financial information provided for the period of Start Date End Date

Expenses

Personnel

Operating

Capital

Other

(Explain in narrative)

Funding Sources and Revenue

Ambulance Tax District (*If contractual from City or County, enter under "Other"*)

Fire Tax District

Hospital Tax District

General Fund
(City or County General Funds)

State Motor Vehicle Fund
(Idaho Motor Vehicle Registration fund from county clerk)

Grant Funds
(Include all grant sources)

Billing for EMS Services
(If not billing, enter "0" and explain in narrative)

Number of billed calls for same time period

Donations
(Explain in narrative)

Cash on Hand
(Explain in narrative)

Investment Income
(e.g. interest, rent, dividends, etc.)

Other
(Explain in narrative)

GUIDELINES AND IMPORTANT INFORMATION

Applying for EMS Vehicles

If requesting a vehicle, it must be for providing emergency medical services only. Funding for ambulances will only be awarded to those agencies having at least one ambulance transport license type. Funding for medical rescue, rescue/extrication, and/or other related purposes is also available.

Email emsgrants@dhw.idaho.gov and request a copy of your agency Vehicle Fleet Report, update the information, and return it as an attachment to the application. Please allow five (5) business days for a response.

Vehicle price caps are located on page 15 of this application.

Firefighting vehicles, snowmobiles, boats, all-terrain vehicles, trailers, etc. will not be funded.

Applying for EMS Equipment

Requested equipment must be appropriate based on clinical level of license types and associated scope of practice.

An equipment price cap has been set at $25,000 per agency (and extended to $80,000 for Multiple Organization EMS agencies as defined in IDAPA 16.01.03.200.04) in order to allow for more applicants to receive awards.

Extrication Equipment has been price capped at $10,000. If you are given an award for extrication equipment, you need to submit a letter affirming that you operate at the Extrication Operations level and provide a list of all personnel trained at the Extrication Operations level. You will also need to provide the Bureau with proof of equipment-specific training after the purchase is made.

A group of related items may be requested as one priority if it adheres to the definition of a kit. A kit is defined as "a group of items that will not work without the other pieces for a specific purpose." The "kit" must be advertised or cataloged as a kit by the vendor.

Identical items may be requested based on the number of licensed personnel listed on the most recent agency renewal application, and may be listed under one priority item request. If requesting communications equipment, the equipment you are requesting must be compliant with your local emergency communication system.

Equipment price caps are located on page 15 of this application.

No funding will be provided for training, firefighting equipment or disposable supplies (including epi auto-injectors). Additional ineligible items are listed on page 16 of this application.

If you are awarded a vehicle you must obtain and provide documentation of appropriate insurance yearly for the life of the lien.

If you are awarded equipment, you must maintain it in good working order or replace it for 5 years after purchase.

SECTION B: Emergency Vehicle Application

If you are NOT applying for a vehicle skip to Section C

If applying for a vehicle, please contact the Bureau to obtain an "Agency Vehicle Fleet Report" to supplement this section. Remember to UPDATE the mileage. Email emsgrants@dhw.idaho.gov.

1. Type of Vehicle Requested

Vehicle Type _____

2. Requested Vehicle Information

Make-chassis manufacturer *(Ford, Dodge, Chevy,etc.)* _____

Vehicle vendor/modifier *(Horton, Wheeled Coach, etc.)* _____

Purpose *(Medical Rescue, Patient Transport, etc.)*

Configuration *(Type I, II, or III Ambulance, Modified van, etc.)*

Vendor Quote *(attach document)*

Amount Requested *(cannot exceed price cap)*

3. Mileage Type and Purpose of Similar Vehicles Currently in Use

Review the Agency Vehicle Fleet Report obtained from the EMS Bureau and make any changes directly on the report and attach to application. This information is used in calculations, so it is important that it is current and complete.

4. Age and Condition of Vehicle Being Replaced *(if applicable)*

Vehicle License Plate No. _____

Chassis Manufacture Year _____

Vehicle VIN Number _____

CONDITION OF VEHICLE *(Select one)* ○ Excellent ○ Good ○ Fair ○ Poor ○ Very Poor

Plans for vehicle being replaced:
(i.e. sold, donated, used for non-EMS purpose) _____

Attach copy of vehicle title or registration for the vehicle being replaced.

SECTION B-1: Vehicle Description of Need Narrative Form

Agency Name

Call Volume for 2017 calendar year *(Idaho EMS responses only)*

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please mention how many vehicles are in your agency's fleet and how many miles your fleet drives annually. For nontransport vehicle requests, include the number of injury crashes your agency responded to in the last calendar year and how many of these crashes required extrication. Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

SECTION C: Priority 1 Equipment Application

1. Equipment Request

Item:

Quantity

Purpose

Patient type for which equipment may be used

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)*

Average length of time (in minutes) the equipment would be used for a patient,
(whole numbers only, i.e. 2 hours = 120 minutes)

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap)*

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

Distance in miles to closest similar equipment:

Time in minutes to closest similar equipment:

Quantity
(number of similar items you have - whole numbers only)

Are you replacing (and removing from service) your similar items with this priority one request?

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE *(Select one)*

Excellent Good Fair Poor Very Poor

Year Manufactured

3. Equipment Narrative Description of Need: Priority 1

A detailed narrative is required for each priority request.

Agency Name	
Priority 1 Item	
Call Volume for the 2017 calendar year (*Idaho EMS responses only)*	

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plan developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

SECTION C: Priority 2 Equipment Application

1. Equipment Request

Item:

Quantity

Purpose

Patient type for which equipment may be used _____

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)* _____

Average length of time (in minutes) the equipment would be used for a patient,
(whole numbers only, i.e. 2 hours = 120 minutes)

_____

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap)*

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

Distance in miles to closest similar equipment: _____

Time in minutes to closest similar equipment: _____

Quantity
(number of similar items you have - whole numbers only)

_____

Are you replacing (and removing from service) your similar items with this priority two request?

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description _____

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE *(Select one)*

○ Excellent ○ Good ○ Fair ○ Poor ○ Very Poor

Year Manufactured

_____

3. Equipment Narrative Description of Need: Priority 2

A detailed narrative is required for each priority request.

Agency Name	
Priority 2 Item	

Call Volume for 2017 calendar year (*Idaho EMS responses only)*

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

SECTION C: Priority 3 Equipment Application

1. Equipment Request

Item:

Quantity

Purpose

Patient type for which equipment may be used

For how many calls do you anticipate using this equipment in the next year? *(whole numbers only)*

Average length of time (in minutes) the equipment would be used for a patient,
(whole numbers only, i.e. 2 hours = 120 minutes)

Vendor Quote *(attach documentation)*

Amount Requested *(can't exceed price cap*)

2. Similar Equipment Currently in Use By Your Agency: similar equipment is used for the same purpose as the requested item and would be subject to the same price cap. For example, a gurney and power gurney would NOT be similar equipment since they have different price caps.

For the next two questions, "similar equipment" refers to equipment already owned and in use by your agency or a neighboring agency with which you have a mutual aid agreement. "Similar equipment" is used for the same purpose as the requested equipment item. For example, if you plan to replace a current equipment item with the requested equipment item, then the distance would be "0 miles same station" and the time would be "0 min same station." If the only similar equipment your agency has access to is kept at a neighboring agency's station eight miles and 14 minutes away, then the distance would be "6-10 miles" and the time would be "11-20 min." If your agency does not currently have similar equipment and has no mutual aid agreement that gives access to similar equipment, then the distance would be "equip not available" and the time would be "equip not available"

Distance in miles to closest similar equipment:

Time in minutes to closest similar equipment:

Quantity
(number of similar items you have - whole numbers only)

Are you replacing (and removing from service) your similar items with this priority three request?

ONLY fill out this section if you ARE REPLACING (and removing from service) equipment. If you are NOT REPLACING (i.e. adding to) equipment, please skip to the next page.

Similar Equipment Item description

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE *(Select one)*

Excellent Good Fair Poor Very Poor

Year Manufactured

3. Equipment Narrative Description of Need: Priority 3

A detailed narrative is required for each priority request.

Agency Name

Priority 3 Item

Call Volume for the 2017 calendar year (*Idaho EMS responses only)*

The communication equipment requested has been reviewed by the County or Regional Communications Center providing services to my agency, and/or the District Interoperability Governing Board (DIGB) and is compliant with the communications plans developed.

To give the Grants Subcommittee a better idea of your agency's situation, please describe the need and lack of funding availability from other sources. Please indicate on how many calls in the last three years the equipment was used (or was needed, if equipment was unavailable). Remember to include an explanation of donations, cash on hand, and other revenue listed on Page 4 of this application.

SECTION D: Signature Page

As an authorized representative (i.e. president, licensed EMS agency administrator) for my agency, I certify that the information provided in this application document, including any attached supplemental information, is complete and accurate.

I also understand that providing false information on any application or document submitted under these rules is grounds for declaring the application ineligible, and that any and all funds determined to have been acquired on the basis of fraudulent information must be returned to the EMS III Account.

I acknowledge that if my agency is granted an award, the funds will be mailed to the address associated with the tax ID number on file with the State of Idaho Controller's office.

Further, I acknowledge that if my agency is granted an award, my agency will be required to provide follow up documentation to the Bureau.

For all awards, this includes:

A completed Accounting Form with supporting documentation.

For vehicle awards, this includes:

A copy of the vehicle specifications at the time of the purchase contract is accepted/ executed.

Proof of obligation of funds;

Title listing the Bureau of EMS & Preparedness listed as lienholder;

Insurance certificate showing Bureau of EMS and & Preparedness listed as lienholder;

and A completed Vehicle Replacement Form.

For extrication equipment awards, this includes:

Documentation of training on the awarded equipment within 30 days of equipment receipt.

Name of Individual Completing Application: _____

Name or Signature of Person Authorizing Application: _____

Title: _____

Date: _____

FY2019 VEHICLE PRICE CAPS

Vehicle Type	Price Cap
Ambulance (Transport)	$125,000
Non-Transport/Rescue	$65,000
Ambulance Remount	$87,500

Note: Any additional expenses due to add-ons to the vehicle that are above the price cap are the responsibility of that agency

FY2019 EQUIPMENT PRICE CAPS

Approved Equipment	Price Cap	Comments
AEDs	$1,695	Base Model
Alternate Transport Device*	$20,000	*Medical Director Letter Required***
Automatic Transport Ventilators	$2,800	*Medical Director Letter Required***
ALS Cardiac Monitor	$20,000	*Medical Director Letter Required***
BLS 12 Lead Device	$7,000	*Medical Director Letter Required***
Computers Desktop Laptop Tablet	 $650 $800 $550	
Extrication Package	$10,000	Must have appropriate training
Gurney Manual Power Power Gurney Load System	 $5,000 $13,500 $20,000	
Mechanical CPR Device	$10,000	*Medical Director Letter Required***
Oxygen Cylinder Loading System	$2,000	Portable/External models only
Pulse Oximeter (with or without CO monitoring)	$500	Base – stand alone units (NOT part of a BP Monitor Kit)
Scene Lighting	$1,000	
Stair Chair Standard Mechanized	 $1,000 $2,500	
Video Laryngoscope	$1,500	*Medical Director Letter Required***

* Alternate Transport Device
The Alternate Transport Device must have the ability to appropriately and securely transport a patient supine, and it shall be listed as a single line item on an equipment application.

- Not otherwise on the 'ineligible' list

The quote accompanying the equipment application must be inclusive of all manufacturer or dealer modifications necessary for the safety and security of the patient. The retention system shall not fail when subjected to manufacturers recommended load.

** Template enclosed

INELIGIBLE ITEMS LIST

The following items have been determined as INELIGIBLE by the Emergency Medical Services Advisory Committee:

1. Avalanche Beacons
2. Digital Camera
3. Disposable items (includes radio batteries, AED pads, bandaging supplies, medications, etc.)
4. Doppler scope
5. Firefighting equipment or vehicles, snowmobiles, boats, All-Terrain Vehicles, trailers, etc.
6. Power Generators
7. MAST
8. Pulse Oximeter/Vital Sign Monitor combination device (standalone oximeters are eligible)
9. Repeaters, Duplexers
10. SAM Splints
11. Structural Firefighting Turnouts
12. Training Equipment

NON-TRANSPORT AGENCIES ONLY

13. Power Gurney
14. Power-load systems

- NO funding for items beyond current scope of practice
- Number of items for personnel may not exceed roster included with the most recent licensure application.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▸ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

{TEMPLATE}

[Date]

EMSAC Dedicated Grant Review Committee,

I have reviewed the grant application for **[Service Name]** and agree with the stated need and appropriateness of the requested equipment listed below. If the requested equipment should require specific training for use as a part of the Optional Module program I will ensure that an appropriate number of the members receive this training, and are credentialed by me to provide the procedures relating to the equipment requested prior to it being put into use by the EMS agency.

Equipment requested and endorsed:

Respectfully,

Medical Director