



FY 2021 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. Contact the bureau at (208) 334-4000 and ask for the grant team if you have questions. 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 FY2021 webinar is posted on the grants page of the EMS website at www.idahoems.org. This year, the webinar will be held on February 20, 2020 at 7pm MST.

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 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/). It is recommended that all agencies save a copy of the application locally on their computer. An email confirmation will be sent to the agency upon receipt of the application. If you do not receive email confirmation within 24 hours of sending your application, assume it was not received. You can also verify receipt on the Grant web page at www.idahoems.org.

Application Due: On or before April 1, 2020

	Email – Preferred method	In Person	Mail	Fax
Submission Methods	emsgrants@dhw.idaho.gov	2224 Old Penitentiary Rd Boise, Idaho, 83712	Bureau of EMS and Preparedness PO Box 83720 Boise, ID 83720-0036	208-334-4015
Send Deadline	11:59 p.m. April 1, 2020	5:00 p.m. April 1, 2020	Postmarked: April 1, 2020	11:59 p.m. April 1, 2020

For Bureau Use Only

Method of Receipt
Email
Fax
In Person
Mail

Date and Time Received: _____

Date Postmarked: _____

REMINDER!

The webinar has proven helpful for applicants and most who attend are awarded items. Please consider joining us this year!

February 20, 2020 7pm

Required Attachment Checklist

1. County, Fire District or incorporated city government (in your primary response area) endorsement(s)
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 all fields of 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. Type of Service Summary Report. This report (generated from patient care record software or dispatch programs) shall have a simple summary listing of the following categories and provide a count for each type of call:
 - 9-1-1 Response (Scene)
 - Intercept
 - Interfacility Transfer
 - Medical Transport
 - Mutual Aid
 - Standby
8. **CONDITIONAL:** Medical Director Endorsement



FY2021 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 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 Number _____ Federal Tax ID Number _____

Agency Type _____ Registry No. Secretary of State
(required for non-profit status) _____

Contact Name _____

Daytime Phone Number _____ Email _____

Number of licensed Volunteer Providers _____

Total Licensed Providers (career and volunteer) _____

2. DEMOGRAPHICS

Verifiable Call Volume for Calendar Year 2019 (*Idaho EMS Responses Only*) _____
(Please attach a Type of Service Summary Report for verification)

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

Attach county and/or city government endorsement(s). Only one (1) is required to receive full points for category.

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*
- *Fire Districts*
- *One of the above endorsements must be the vehicle title holder if you are requesting a vehicle*
- *Endorsements from taxing districts are not acceptable*

If applying for a vehicle, the name of the incorporated city, county, or Fire District to be the titleholder

3. FINANCIAL AND OPERATING INFORMATION

Provide financial operating information for one full fiscal year. This shall 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 _____

Funding Sources and Revenue

Taxing Funds (Ambulance Tax, Fire Tax District, Hospital Tax District, General Funds)	_____	Billing for EMS Services (If not billing, enter "0" and explain in narrative)	_____
State Motor Vehicle Fund (Idaho Motor Vehicle Registration fund from county clerk)	_____	Number of billed calls for same time period	_____
Grant Funds (Including all grant sources)	_____	Investment Income (e.g. interest, rent, dividends, etc.)	_____
Donations (Explain in narrative)	_____	Other (Explain in narrative)	_____
Cash on Hand (Explain in narrative)	_____		

GUIDELINES AND IMPORTANT INFORMATION

Applying for EMS Vehicles

If requesting a vehicle, it must be for providing emergency medical services only. The vehicle must be on the EMS License and is subject to inspection. Funding for ambulances will only be awarded to those agencies having at least one ambulance transport license type. Funding for medical rescue and rescue/extrication 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.

Newly manufactured ambulances must be compliant with the current (as of order date) standards of either KKK-A-1822, NFPA 1917, or CAAS GVS.

Vehicle price caps are located on page fifteen (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 as approved by the Idaho EMS Physician Commission.

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

Extrication Equipment has been price capped at seven thousand five hundred (\$7,500). 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 as one priority 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 fifteen (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 sixteen (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. You are also responsible for maintenance and keeping it in good working order for the duration 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. LAST YEAR VEHICLE WAS AWARDED

Year Awarded _____

3. REQUESTED VEHICLE INFORMATION

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

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

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

Vendor Quote (attach document) _____

Amount Requested (cannot exceed price cap) _____

4. 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.

5. AGE AND CONDITION OF VEHICLE BEING REPLACED

Vehicle License Plate Number _____

Chassis Manufacture Year _____

Vehicle VIN Number _____

CONDITION OF VEHICLE (Select One)	Excellent	Good	Fair	Poor	Very Poor
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Plans for vehicle being replaced:
(i.e. sold, donated, used for non-EMS purposes) _____

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 2019 calendar year (Idaho EMS responses only) _____

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 non-transport 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 _____

Patient Type _____

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 (cannot exceed price cap) _____

2. SIMILAR EQUIPMENT

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 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 next page.

Similar Equipment Item Description _____

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE (Select One) Excellent Good Fair Poor Very Poor

Year Manufactured _____

SECTION C-1: PRIORITY 1 EQUIPMENT NARRATIVE

Agency Name _____

Item Requested _____

Call Volume for 2019 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: PRIORITY 2 EQUIPMENT APPLICATION

1. EQUIPMENT REQUEST

Item _____ Quantity _____

Patient Type _____

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 (cannot exceed price cap) _____

2. SIMILAR EQUIPMENT

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 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 next page.

Similar Equipment Item Description _____

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE (Select One) Excellent Good Fair Poor Very Poor

Year Manufactured _____

SECTION D-1: PRIORITY 2 EQUIPMENT NARRATIVE

Agency Name _____

Item Requested _____

Call Volume for 2019 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 E: PRIORITY 3 EQUIPMENT APPLICATION

1. EQUIPMENT REQUEST

Item _____ Quantity _____

Patient Type _____

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 (cannot exceed price cap) _____

2. SIMILAR EQUIPMENT

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 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 next page.

Similar Equipment Item Description _____

CONDITION OF EQUIPMENT USED FOR SAME PURPOSE (Select One) Excellent Good Fair Poor Very Poor

Year Manufactured _____

SECTION E-1: PRIORITY 3 EQUIPMENT NARRATIVE

Agency Name _____

Item Requested _____

Call Volume for 2019 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 F: 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 or incomplete 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 the tax ID number on the attached W-9 is associated with the address provided. If my agency is granted an award, the funds will be mailed to the address provided on the attached W-9.

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 and Preparedness listed as lienholder

Insurance certificate showing Bureau of EMS and Preparedness listed as lienholder

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:

Signature of Person Authorizing Application:

Title:

Date:

FY2021 VEHICLE PRICE CAPS

VEHICLE TYPE	PRICE CAP
Ambulance (Transport)	\$135,000
Non-Transport/Rescue	\$65,000
Ambulance Remount	\$95,000

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

FY2021 EQUIPMENT PRICE CAPS

Approved Equipment	Price Cap	Comment
AEDs	\$1,700	Base Model
Alternate Transport Device*	\$20,000	<i>Medical Director Letter Required**</i>
Automatic Transport Ventilators	\$3,000	<i>Medical Director Letter Required**</i>
ALS Cardiac Monitor	\$22,500	<i>Medical Director Letter Required**</i>
BLS 12 Lead Device	\$3,000	<i>Medical Director Letter Required**</i>
Computers Desktop	\$650	
Laptop	\$800	
Tablet	\$550	
Extrication Package	\$7,500	Must have appropriate training
Gurney Power Gurney Retrofit Kit	\$2,500	
Manual	\$5,000	
Power	\$14,000	
Power Gurney Load System	\$21,000	
Power Gurney and Load System Kit	\$25,000	<i>Must be identified as "Kit" on Quote</i>
Mechanical CPR Device	\$11,000	<i>Medical Director Letter Required**</i>
Oxygen Cylinder Loading System	\$2,000	Portable/External models only
Pulse Oximeter (without CO monitoring)	\$500	Base – standalone units
(with CO monitoring)	\$1,250	(NOT part of a BP Monitor Kit)
Stair Chair Standard	\$1,000	
Mechanized	\$2,500	
Video Laryngoscope	\$2,000	<i>Medical Director Letter Required**</i>

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

****Template enclosed**

INELIGIBLE ITEMS LIST

NO funding for items beyond current scope of practice

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. Vital Sign Monitor combination device (standalone oximeters are eligible)
8. Repeaters, Duplexers
9. Structural Firefighting Turnouts
10. Training Equipment
11. Ballistic Equipment
12. Equipment used solely for a trial basis or pilot project

NON-TRANSPORT AGENCIES ONLY

13. Retrofit Power Gurney
14. Power Gurney
15. Power – Load System
16. Power Gurney and Load System Kit

- Number of items for personnel may not exceed roster included with the most recent licensure application



Request for Taxpayer Identification Number and Certification

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

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	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 of the person whose name is entered on line 1. Check only one of the following seven boxes.	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
	<input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	Exempt payee code (if any) _____
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.	Exemption from FATCA reporting code (if any) _____
	<input type="checkbox"/> Other (see instructions) ▶ _____	<i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 for Part II, later.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

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, later.

Medical Director Endorsement

((DATE))

EMSAC Dedicated Grant Review Committee,

I have reviewed the grant application for **((AGENCY))** 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 part of the Optional Module program I 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