Agency Legal Name (as listed on your EMS Agency license):

Federal Tax ID Number:

Agency Type (pursuant to EMS Act 37, Chapter 81, Sections 8129-8138):

Check all that apply.

__ BLS
__ ALS
__ BLS Squad
__ ALS Squad
__ QRS
__ Air Ambulance
__ Special Operations EMS
__ First Aid and Other Safety Services
___ Critical Care Trans
__ Other Vehicles and Services

Mailing Address of EMS Agency:

Street:
City: State: Zip:

County:

Primary EMS Service Provider: Yes or no check box

Name of Local Government Primary Response Area (if applicable): Name of township/boroughs, etc. within primary response area?

Grant Amount Requested:

Application Preparer (This must be a manager, owner, or executive officer authorized to submit this application):

Name:
Primary Telephone Contact:
Secondary Telephone Contact:
Email Address (This will be the primary communication method):

Agency Characteristics

Number of Volunteer Practicing Providers:

Number of Career Practicing Providers:
Number Full-Time:

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Number Casual or Part-Time:

Number of Agency Stations:

Agency Vehicles (Number of each):

____ BLS, Primary
____ BLS, Reserve
____ ALS, Primary
____ ALS, Reserve
____ BLS Squad
____ ALS Squad
____ QRS – Please describe:
____ Other not specified above – Please describe (for example, Chief's vehicle):

_____
_____
_____
_____

PA EMS Agency License Number:
PA EMS Agency License Expiration:

Average Annual Call Volume over the past 3 years:

____ Total Responses
____ Total Patient Transports (below percentages must total 100%)
____ % BLS Emergency Transports
____ % ALS Emergency Transports
____ % Non-Emergency Transports (via Ambulance)
____ % Non-Emergency Transports (other than via Ambulance)
____ % Other (Stand-by Ops, Cancelled Enroute, etc.)

Average Annual Operating Budget over the past 3 years: (We are going to need more details/direction here – from previous surveys, this is a subjective interpretation).

Percentage of Annual Operating Budget derived from (below percentages must total 100%):

____ Taxes
____ Grants
____ Donations
____ Fund Drives – Fund Raising Events
____ Payments for Services Provided
____ Other (Describe)

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Equipment / Supplies for which funding is being applied for: (if multiple items, please list each item in order of priority). You must not have received other funding for the purchase of these items.

ITEM(S)	TOTAL COST	DATE PURCHASED (actual or planned)	FUNDS REQUESTED
		TOTAL FUNDS REQUESTED	

20 lines are available on line.

Please provide a brief overview, **NO MORE THAN 500 WORDS**, of how these items will/were to be used, justification for their need and the intended benefit for your agency and the community served:

Financial Institution:
Please provide the banking information for electronic funds transfer.
Bank Name:
Routing Number:
Account Number:

This completes the application for grant funds provided by Highmark, Inc. with the assistance of the Pennsylvania EMS Provider Foundation.

DO NOT send additional information (e.g. – invoices from previous purchases, letters of support, etc.) with this application. Documentation will be required for the applicant's final report.

Please ensure that your application is complete prior to submission as you may only submit one application. Any missing information may result in disqualification. There will not be an option to submit supplemental requests or additional information after your application is received. You will receive a copy of your submitted application, which will also serve as your confirmation that the application received.

Check Box: By clicking this box, I have the authority to submit this application on behalf of my EMS agency.

Check Box: By clicking this box, I attest that the information provided is true and correct.

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Check Box: By clicking this box, I agree to provide the required report by December 31, 2021 or return the funds to the PA EMS Provider Foundation.

Electronic Signature Box: Name and Title

SUBMIT BUTTON

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