INTERIOR REGION EMERGENCY
MEDICAL SERVICES COUNCIL, INC.
2503 18th Avenue • Fairbanks, Alaska 99709
Phone (907) 456-3978 • Fax (907) 456-3970

# Mini Grant Application for FY 19
## (July 1, 2018 - June 30, 2019)
## DEADLINE: JUNE 22, 2018

Thank you for your interest in the IREMSC Mini-Grant Program. In order to be eligible for a Mini-Grant you will need to provide the following information (This applies even if you received a mini-grant in the last year):

- Completed Mini Grant Application
- **If you are a State Certified Ambulance Service:**
    - Proof of State Ambulance Certification
- ***If you received a minigrant last year (Fiscal Year 18- July 1, 2017 - June 30, 2018), you must include:***
    - *an Annual EMS Survey for Calendar Year 2017 (January - December) (see enclosed)If you provided this during the recent Code Blue Grant process you do not need to send another one.*
- ***If you received an IREMSC Inventory Verification List***, *(list of equipment purchased by grants and assigned to your service) this must also be returned to IREMSC prior to your service being eligible for approval of an FY19 Mini-Grant. (The Inventory verification list is being mailed out under separate cover.)*

If you have any questions regarding the application for a Mini-Grant or need help with the requested documentation, please contact Wilma Vinton in our office. If you would like a type-able version of this application, you can go to our website at www.iremsc.org , select *Downloads* from the Site List on the right side.

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**Mini Grant Application for FY 19**
**(July 1, 2018 - June 30, 2019)**


***PLEASE PRINT CLEARLY OR TYPE***

**EMS SERVICE / APPLICANT INFORMATION:**

*Service's Full Name*: ______________________________________________
*Service Mailing Address:*______________________________________________
*City:*_____________ _____________*State: AK Zip*________________________
*Service Phone Number for routine contact:*________________________________
*Service Fax Number:*________________________________
*Service E-mail for routine contact:*_______________________________________
*Service Chief or Leader:* ______________________________________________
*(if different from Service:)*
*Chief Mailing Address:*_________________________________________________
______________________________________________________________________
*Chief Phone Number*_____________ *Chief Email*___________________________

**MINI GRANT CONTACT INFORMATION:**

*Contact Person for Mini Grant Business (if different from the Chief/Leader above):*

*Name:* ___________________________________

*Phone:* ___________________________________

*Email:* ___________________________________

*Mailing Address* (***if different from above***):

___________________________________________

___________________________________________

# Interior Region EMS Council
## Mini Grant Application for FY 19
## Page 2

1. Is your service in a city or borough that has a government managed EMS Service? Yes ____ No ____

   *If yes, your service may not be eligible for a Mini Grant. Please contact our office for clarification if you are unsure whether this applies to you.*
   Borough or Government Name______________________________

2. We are applying as a: (check one):

   ____ Alaska Certified Ambulance Service (*attach Proof of Certification*)

   ____ Non-Certified Ambulance or First Responder Squad

3. You must have someone able to respond when called, 24 hours a day 365 days a year and at least one member trained to the ETT or higher level able to respond at all times.

   Not everyone has to be ETT or above. But, unless you can explain how it would work otherwise, this will require at least four active ETT's/ Health Aide in your squad.

   Please list all active squad members' names and their level of training or certification. Use an attached sheet if necessary.

   A. ______________________________________________

   B. ______________________________________________

   C. ______________________________________________

   D. ______________________________________________

4. Describe your response area (use additional sheet for description or attach a map):

   ______________________________________________

   ______________________________________________

   ______________________________________________

   ______________________________________________

5. What dispatch system do you use to alert responders of an emergency? **911** □ Location of Dispatch Center :________________ OR
   **A direct Phone Number** □, What Agency manages the line and what phone number is called?______________________________________________

6. Do you have written policies regarding training to keep your responders' skills and certification current?

   ____ Yes ____ No ***If you have a written policy, please attach.***

   **<u>If you do not have a written policy</u>**, briefly describe how your responders' skills and certifications will be kept current (attach additional information if needed:______________________________

   ______________________________________________

   ______________________________________________

   ______________________________________________

7. a) Please complete the equipment list in the Appendix (Last Pages).
   b) Where do you keep your equipment? ______________________________

   c) How do you keep track of your equipment? ______________________________

   ______________________________________________

8. How do you determine who is in charge when you respond to an incident? ____________________

   ______________________________________________

9. Do you agree to respond to ALL medical emergencies within your response area? ____ Yes ____ No

10. How do you get a patient from your community to a higher level of care? ***Check all that apply***:

☐ Ambulance ☐ Personal Vehicle ☐ Commercial Airplane
☐ EMS Transport Vehicle ☐ Medevac ☐ Other_________________

11. Do you agree to keep a record for each patient that you take care of on a state-approved report form and maintain a copy of each patient report on file consistent with current statutes regarding medical record keeping, ***OR*** use the AURORA data collection system? ____ Yes ____ No

(*Note: Certified Ambulance Services are now required to submit data to the AURORA data collection system, either directly or by uploading files. This does not apply to non-certified services)*

Which method of completing Patient Care Reports (PCR's) will you use (***choose one***):
____ Paper Patient Care Reports (non-certified services)
____ Aurora Data collection, directly
____ Aurora Data collection via uploading files

12. Do you agree not to discriminate regarding religious preference, race, color creed, national origin, or financial status in the provision of emergency medical services. ____ Yes ____ No

13. For this FY 19 Mini Grant, you are required to complete the Annual EMS Survey (attached) for the calendar year 2017. Do you agree to this requirement?

____ Yes ____ No

15. Do you agree to provide documentation as requested to the Interior Region EMS Council? ___ Yes ___ No

If you have a Medical Director, please complete the following information:

*Name:* _________________________ _________________________________________________

*Phone:* __________________________ *Email:* ___________________________________

*Mailing Address:* _________________________________

___________________________________________

*I agree that the above information is accurate to the best of my knowledge (both must sign, or indicate if they are the same person).*

**Mini Grant Contact**: ___________________________________________________________________
Printed Name Signature Date

**Service Chief or Leader**: ___________________________________________________________________
Printed Name Signature Date

**MINI-GRANT APPLICATION**

**APPENDIX- EQUIPMENT CHECK LIST**

**NOTE: Only Check the equipment that applies to your level of Service, (if you are not an ALS service, you do not need to have ALS equipment.**

## FIRST RESPONDER EQUIPMENT/SUPPLIES

**Basic Life Support (BLS)**

**INDIVIDUAL EQUIPMENT**

***RESPONSE BAG WITH THE FOLLOWING EQUIPMENT:***

☐ Body fluid isolation devices and supplies (gloves, masks, gowns, eye protectors)
☐ Universal dressings or trauma dressings
☐ 4 x 4 gauze pad packs
☐ Roller bandages (i.e. Kerlex or Kling type)
☐ Adhesive tape, various sizes
☐ Burn sheets, sterile
☐ Triangular bandages with safety pins
☐ Trauma shears
☐ Occlusive dressings (foil, plastic wrap, or Vaseline-covered gauze dressings)
☐ Sterile saline for irrigation
Blood pressure cuff
☐adult, ☐pediatric ☐large adult size (recommended)
☐ Stethoscope
☐ Penlight
☐ Activated charcoal, 25-50 grams
☐ Substance high in sugar for treatment of diabetic patients (i.e. Glucose)
☐ Emesis basin/bag
☐ Protective gloves, leather **SQUAD**

**EQUIPMENT *IMMOBILIZATION***

Cervical collars,
☐ adult ☐ pediatric
☐ Long spine board *with* ☐padding ☐head chocks and ☐straps
☐ Short backboard, KED, or equivalent
☐ Pediatric backboard or equivalent
Traction splint
☐ adult ☐ pediatric
Extremity splints(e.g. vacuum, air, padded board, Sam splint etc.)
☐ adult ☐ pediatric
☐ Blankets

***MISCELLANEOUS:***

☐ Safety flares/lights/markers
☐ 5 lb. fire extinguisher, dry chemical
☐ Hammer, Phillips screwdriver, regular screwdriver, adjustable wrench, and pliers (Vehicle Repair Kit)
☐ Flashlight

***OBSTETRICAL:***

☐ Obstetrical kit, sterile

☐ Thermal blanket (to help newborn maintain body heat)

***COMMUNICATIONS:***

☐ Two-way communications radio Handheld________________________(Make) (Frequencies)

☐ Base Station radio____________________________________________(Make)

***PATIENT TRANSPORT:***

Patient transport: *check all that apply* : ☐Ambulance ☐Non-amb vehicle ☐Sled

☐ Stretcher/Stokes liter, portable - with appropriate patient restraining device

***OPTIONAL MEDICATIONS/EQUIPMENT:***

☐ Aspirin

☐ Epi auto injector

☐ Automatic external defibrillator (AED)

☐ Portable oxygen tank with regulator

☐ Oxygen connection tubing

☐ Non-rebreathing masks, adult and pediatric sizes

☐ Oxygen masks, infant

☐ Oxygen cannulas, adult and pediatric

☐ Adult bag-valve-mask with reservoir and mask

☐ Pediatric bag-valve-mask with reservoir and pediatric mask

☐ Infant bag-valve-mask with reservoir and infant mask

☐ Portable suction unit

☐ Suction catheters (6F-14F)

☐ Rigid suction tip (e.g., Yankaur)

☐ Pediatric bulb syringe (usually in the OB kit)

☐ Suction rinsing water bottle

☐ Oropharyngeal airways (00-5), adult ☐, pediatric ☐, and infant ☐

☐ Nasopharyngeal airways, sizes 18F-34F or 4.5 - 8.5 mm

☐ Water-soluble lubricant

☐ Portable extrication equipment

## ADVANCED LIFE SUPPORT (ALS) EQUIPMENT/SUPPLIES

***EMT-II EQUIPMENT/SUPPLIES:***

- ☐ Advanced Airway Device and associated administration equipment
  Type: check all that apply: ◻ ET ◻ Combi-Tube ◻ King Airway ◻ Other (list)________
- ☐ End tidal C02 detection device Type: ☐Colormetric ☐ Monitor
- ☐ Naloxone HCI
- ☐ 50% Dextrose in Water
- ☐ Balanced Salt Solution (e.g., normal saline)
- ☐ Syringes of various sizes
- ☐ Needles of various sizes
- ☐ Three-way Stopcocks (desirable but not required)
- ☐ Tubes for Blood Samples (optional)
- ☐ Pediatric Medication Dosage Chart
- ☐ IV Catheters (14-24 Gauge)
- ☐ IV Sets ☐Mini (60 gtts/cc) ☐Maxi (10, 12, or 15 gtts/cc)
- ☐ Intraosseous Needles ☐ Adult ☐ Peds
- ☐ Glucometer

***EMT-III EQUIPMENT/SUPPLIES:***

- ☐ Manual Defibrillator
- ☐ Pediatric paddles/patches for defibrillator
- ☐ Monitoring electrodes - adult and pediatric sizes
- ☐ Defibrillator Gel/Pads
- ☐ Lidocaine 20% or pre-mixed bag for drip
- ☐ Morphine Sulphate
- ◻ Epinephrine I1,000
- ◻ Epinephrine I:10,000
- ◻ Atropine
- ◻ Nitroglycerine Sublingual

***PARAMEDIC or ADVANCED SCOPE EQUIPMENT/SUPPLIES:***

- ☐ Adenosine
- ◻ Albuterol
- ◻ Aminophylline
- ◻ Amiodarone
- ◻ Diazepam (Valium)
- ◻ Diltiazem
- ◻ Diphenhydramine (Benadryl)
- ◻ Dopamine
- ◻ Fentanyl
- ◻ Furosemide (Lasix)
- ◻ Glucagon
- ◻ Haloperidol (Haldol)
- ◻ Ipratropium Bromide (Adtrovent)
- ◻ Ketorolac
- ◻ Lorazapam (Ativan)
- ◻ Magnesium Sulfate
- ◻ Methylprednisolone (Solu-Medrol)
- ◻ Midazolam (Versed)
- ◻ Nitroglycerine IV
- ◻ Pitocin
- ◻ Ondansetron (Zofran)
- ◻ Oxymetazoline HCL (Afrin)
- ◻ Hydrochlorine Proparacaine Ophthalmic Solution, 0.5%
- ◻ Sodium Bicarbonate
- ◻ Thiamine

Misc. List ________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________