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 20
(July 1, 2019 - June 30, 2020)
DEADLINE: JUNE 22, 2019

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 19- July 1, 2018 - June 30, 2019), you must include:***
  - *an Annual EMS Survey for Calendar Year 2018 (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 FY20 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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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 20
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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 20 Mini Grant, you are required to complete the Annual EMS Survey (attached) for the calendar year 2018. 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 wi th regulator

☐ Oxygen connection tubing

☐ Non-rebreathing masks, adul t 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 i nfant 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 l8F-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 _____
_____
_____
_____
_____
_____
_____
_____