

RECORDED

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PAGE NO.

R-94-209

MINUTE BOOK NO.

43

A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS, OF MANATEE COUNTY, FLORIDA, AUTHORIZING THE SUBMISSION OF AN APPLICATION TO THE FLORIDA DEPARTMENT OF HEALTH AND REHABILITATION SERVICES, OFFICE OF EMERGENCY MEDICAL SERVICES UNDER THE MATCHING GRANT PROGRAM.

WHEREAS, the State of Florida Department of Health and Rehabilitative Services, Office of Emergency Medical Services provides matching grant funding to assist public organizations improve and expand their EMS systems; and

WHEREAS, the Manatee County Department of Public Safety, Division of Emergency Medical Services is eligible to participate in the matching grant program; and

WHEREAS, the Manatee County Department of Public Safety, Division of Emergency Medical Services has identified the need for a differential GPS Automatic Vehicular Location System for the County's fleet of ambulance and dispatch center, which will help reduce response times to emergencies in the community.

NOW THEREFORE BE IT RESOLVED, by the Board of County Commissioners of Manatee County, Florida, that:

1. The submission of an application to the Florida Department of Health and Rehabilitative Services, Office of Emergency Medical Services under the Matching grant program is hereby authorized.
2. The Chairman, or in his absence, the Vice Chairman are authorized to execute all appropriate documents with regards to the submission of this application and related documents required pursuant to the application.

ADOPTED with a quorum present and voting this the 19th day of July, 1994.

BOARD OF COUNTY COMMISSIONERS OF  
MANATEE COUNTY, FLORIDA

By: Stan Stephens  
Chairman

ATTEST: R.B. SHORE  
Clerk of the Circuit Court

<COPY-SEE BACK>

ID Code to be Assigned by State EMS Office: M \_\_\_\_\_  
Florida Department of Health and Rehabilitative Services  
Office of Emergency Medical Services (EMS)  
MATCHING GRANT APPLICATION

1. Legal Name of Agency/Organization:	Manatee County Government	
Name and Title of Grant Signer:	Stan Stephens, Chairman, Board of County Commissioners	
Mailing Address:	Post Office Box 1000 Bradenton, Florida 34206	County: Manatee
Telephone Number:	(813) 748-4501	SunCom Number:

2. Name and Title of Contact Person:	Greg Thomas, Captain Emergency Medical Services	
Mailing Address:	1112 Manatee Avenue, West Bradenton, Florida 34205	Suite 525
Telephone Number:	(813) 749-3022	SunCom Number:

3. Legal Status of Agency/Organization: (Check only one)	Your fiscal year:	
	<u>10.1.94</u>	<u>9.30.95</u>
	BEGINS	ENDS
<input type="checkbox"/> Private Not for Profit (you must provide copy of certificate)		
<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Public	

4. Agency/Organization's Federal Tax Identification Number nine digits VF 5 9 6 0 0 0 7 2 7

5. Identify the one state plan objective this project primarily addresses: Objective #: 33.3

6. Type of Project: (Check only one):

<input type="checkbox"/> Communications	<input type="checkbox"/> Continuing Professional Education (medical director must sign item 16a)
<input checked="" type="checkbox"/> Emergency Transport/Vehicles	<input type="checkbox"/> Public Education
<input type="checkbox"/> System Evaluation/Quality Assurance	<input type="checkbox"/> Research
<input type="checkbox"/> Medical/Rescue Equipment (signatures required for items 16b and 16c)	

Does your project include the purchase of any communications equipment?  yes  No

For both the need and outcome statements: include all available numeric data, the time frame for the data, the data source, the number of people who will directly receive project services, and other information which clearly identifies your need and expected outcome for this project.

**7. Need Statement (use only the space below):**

Manatee County EMS CAD and Run Reports records from July, 1993 through June, 1994 reveal that EMS had 21,054 calls with a primary ALS response time of 10.82 minutes or less for 90% of the calls run. Manatee County EMS needs to reduce its primary ALS Total Response time to 8 minutes or less for 90% of the calls run with an automatic vehicle locator system.

**8. Outcome Statement (use only the space below):**

The installation of an automatic vehicle location system would reduce call processing times by identifying the closest available EMS unit to dispatch, and assist the Dispatcher in leading the unit to the location of the call.

**9. Improvement and Expansion of Prehospital EMS. Describe how your project improves and expands prehospital EMS. Also, show how it builds coordination and cooperation with other EMS systems.**

With the addition of an automatic vehicle location system to the ambulance fleet and dispatch center, EMS will be able to improve its ALS total response time from 10.82 minutes or less to 8 minutes or less for 90% of the calls taken.

**10. Research Projects Only:**

If you are not conducting a research project, skip this item and go to item 11.

If you are conducting a research project, attach at the end of the application concise statements of the hypothesis, design/method, instruments, methods to protect human subjects, any limitations involving the study, research instruments, forms and listings of other relevant studies.

**11. Major Work Activities and Time Frames (Use only the space below):**

Bid and purchase system within three months after receipt of grant.

Install, test and implement system within sixty days after receipt of system equipment.

CATEGORIES	APPLICANT Cash Match	State Grant Funds	TOTAL
<b>12. Salaries and Benefits:</b>			
<b>TOTAL SALARIES and BENEFITS</b>			

<b>13. Expenses</b>			
<b>TOTAL EXPENSES</b>			

CATEGORIES	APPLICANT Cash Match	State Grant Funds	TOTAL
<b>14. Equipment:</b>			
Vehicle/Display Equipment	11,050	33,150	44,200
Software/Interface	5,250	15,750	21,000
Installation/Training	2,750	8,250	11,000
PC's (2 @ \$4,000 ea.)	2,000	6,000	8,000
<b>TOTAL EQUIPMENT COSTS</b>	<b>21,050</b>	<b>63,150</b>	<b>84,200</b>

CATEGORIES	APPLICANT Cash Match	State Grant Funds	TOTAL
<b>15. Final Summary - Total of salaries and benefits, expenses and equipment, all combined</b>	<p style="text-align: center;">\$ 21,050 -----</p> <p>The above figure must equal 25 percent of the total</p>	<p style="text-align: center;">\$ 63,150 -----</p> <p>The above figure must equal 75 Percent of the total</p>	<p style="text-align: center;">\$ 84,200 -----</p> <p>The above figure must equal the sum of the preceding two columns</p>

**Note:** You may attach a page or pages to explain and justify as necessary the need for any and all positions, expenses, and equipment in terms of the items, their quantities, their costs, and their roles in the project.

16. **Medical director's signatures:** Complete this item only if your project is a Medical/Rescue Equipment, or Professional Education Project.

**a. Professional Education**

All continuing education described in this application is developed and conducted with my input and approval.

\_\_\_\_\_  
Medical Director's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Director's Printed Name

NOT APPLICABLE

**b. Medical Equipment Projects:**

I hereby accept authority and responsibility for the use of Medical Anti-Shock Trousers (MAST), Esophageal Obturator Airways (EOAs), semi-automatic and automatic defibrillators, ALS equipment identified in Chapter 10D-66, F.A.C., and equipment not identified in Chapter 10D-66, F.A.C. If this responsibility is delegated, both the delegated physician and the medical director must sign this section.

NOT APPLICABLE

\_\_\_\_\_  
Medical Director's Signature  
and Delegated Physician, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Director's Printed Name  
and Delegated Physician, if any

**c. I hereby acknowledge that the applicant responds routinely to rescue or medical incidents under written agreement with my licensed EMS system.**

\_\_\_\_\_  
Medical Director's or Authorized Person's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

NOT APPLICABLE"

APPLICATION ITEM 17 (signature required)

**REQUEST FOR MATCHING GRANT DISTRIBUTION (ADVANCE PAYMENT)  
EMERGENCY MEDICAL SERVICES (EMS)  
Governmental Agency and Non-profit Entity ONLY**

In accordance with the provisions of paragraph 401.113(2)(b), F.S., the undersigned hereby requests an EMS matching grant distribution (advance payment) for the improvement and expansion of prehospital EMS.

Payment To: Manatee County  
Legal Name of Agency/Organization  
Post Office Box 1000  
Address  
Bradenton Florida 34206  
(City) (State) (Zip)

SIGNATURE: Stan Stephens Authorized Official DATE: 7/19/94  
Printed Name: Stan Stephens Title: Chairman

**SIGN AND RETURN WITH YOUR MATCHING GRANT APPLICATION TO:**

Department of Health and Rehabilitative Services  
Office of Emergency Medical Services (HSTM)  
EMS Matching Grants  
1317 Winewood Boulevard  
Tallahassee, Florida 32399-0700

ATTEST: [Signature]  
R. B. SHORE, CLERK OF CIRCUIT COURT

For Use Only by Department of Health and Rehabilitative Services,  
Office of Emergency Medical Services

Matching Grant Amount: \$ \_\_\_\_\_ Grant ID Code: M \_\_\_\_\_  
Approved By: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature, State EMS Grant Officer  
State Fiscal Year: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Organization Code 60-20-60-30-100 E.O. HS Object Code \_\_\_\_\_  
Federal Tax ID V F: \_\_\_\_\_  
Grant Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

## 18. ASSURANCES AND APPLICATION SIGNATURE

### Certification of Standards Statement

I, the undersigned, certify that if granted funds under Chapter 401, Part II, F.S.; as amended, all applicable regulations and standards will be adhered to including: Chapter 401, F.S.; Chapter 10D-66, F.A.C.; Minimum Wage Act; Title VI of the Civil Rights Act of 1964 (42 USC 2000D et. seq.); DHEW Regulation (45 CFR Part 80); Rehabilitation Act (Sec 504); Developmentally Disabled Assistance and Bill of Rights of 1975 (P.L. 95-602) as amended by Title V of the Comprehensive Rehabilitative Services Amendments of 1978: Confidentiality; Human Rights; Habilitation Plans; Employment of the Handicapped; Services for Persons Unable to Pay.

### Statement of Cash Commitment

I, the undersigned, certify that cash match will be available during the grant period and used in direct support of this grant project. State and federal funds will not be used for matching requirements, unless specified by law. No costs or third-party contributions count towards satisfying a matching requirement of a department grant if they are used to satisfy a matching requirement of another state or federal grant. Cash, salaries, fringe benefits, expenses, equipment, and other expenses as listed on this application shall be committed and used for the department's final approved project during the grant period.

### Acceptance of Terms and Conditions

I, the undersigned, accept the grant terms and conditions in Appendix B of the booklet, "1992 Florida EMS Matching Grant Program", by the Department of Health and Rehabilitative Services and acknowledge this when funds are drawn or otherwise obtained from the grant payment system.

### Disclaimer

I, the undersigned, hereby certify that the facts and information contained in this application and any follow-up documents are true and correct to the best of my knowledge, information, and belief. I further understand that if it is subsequently determined that this is not correct, the grant funded under Chapter 401, Part II, F.S. and Chapter 10D-66, F.A.C., may be revoked, and any monies erroneously paid and interest earned will be refunded to the department with any penalties which may be imposed by law or applicable regulations.

### Notification of Awards

I, the undersigned, understand the availability of the notice of award will be advertised in the Florida Administrative Weekly, and that 30 calendar days after this Florida Administrative Weekly advertisement I waive any right to challenge or protest in anyway the decisions to award grants.

### Maintenance of Improvement and Expansion

I, the undersigned, agree that any improvement or expansion brought about in whole or part by grant funds, will be maintained for five years after the project ends, unless specified otherwise in the approved application or unless the department agrees in writing to allow a change. Any unauthorized change within the five years will necessitate the return of grant funds involved, plus interest if any to the department.



Signature of Authorized Grant Signer  
(Individual Identified in Item 1)

  
ATTORNEY  
R. B. SHORE, CLERK OF CIRCUIT COURT



Date

NOTE: Please check to insure that all required signatures have been made for Items 16, 17, and 18. The application will not be considered for funding without any required signature.