

Trauma Grant Application

Step by Step Process

Checklist and Form Instructions

A checklist is provided on the website to help applicants track their progress in completing the application.

Instructions are provided on the checklist to help with each form.



ARKANSAS DEPARTMENT OF HEALTH

Trauma EMS Grant Application

+	<input type="checkbox"/> AASIS Vendor Registration	All agencies who apply for trauma grants must obtain or update the AASIS vendor number. An AASIS number is issued for the State accounting system and must be utilized for any vendor/subcontractor to obtain funds from the State of Arkansas.
	<input type="checkbox"/> Required Information Form	This form is utilized by the Trauma Section to complete the grant packet for trauma grant funds. This form is also used as your response to the solicited proposal of providing services to the trauma system.
	<input type="checkbox"/> Geographic Coverage Area Form	This form is utilized by the Trauma Section to complete the grant packet for trauma grant funds. If the agency provides service to more than one county, please list the areas covered in alphabetical order.
	<input type="checkbox"/> Illegal Immigrant Contractor Disclosure Certification Form	Each agency must submit the illegal immigrant disclosure statement disclosing if you do or do not employ illegal immigrants. Please print the form once it has been submitted and return it with this grant application. If you are a government entity you do not need to submit this disclosure statement.

AASIS Vendor Registrations Instructions

Each trauma grantee needs to obtain (unless they already have one) or update a State vendor number (AASIS Number) by contacting the Office of State Procurement.

To obtain or update a number each potential grantee should fax a W-9 Form to Sheila Kinslow at (501) 324-9311.

You must include a cover sheet with this fax requesting an AASIS Number for grant purposes. The cover sheet must include the name of your agency, mailing address, and telephone number.

Note: The \$25.00 fee will no longer be required, unless you choose to use the Office of State Procurement's website to obtain or update your vendor information.

Vendor Registration (AASIS Number)

Each applicant must have a vendor registration number. This is the number issued in the AASIS System.

This number is obtained by faxing information about your facility to Shelia Kinslow. **Fax Number: (501) 324-9311**

Please include the facility's complete legal name, address, and Tax ID number to be entered into the AASIS system by faxing a cover letter and a w-9 form to Sheila Kinslow.

ARKANSAS DEPARTMENT OF HEALTH Trauma EMS Grant Application	
<input type="checkbox"/> AASIS Vendor Registration	All agencies who apply for trauma grants must obtain or update the AASIS vendor number. An AASIS number is issued for the State accounting system and must be utilized for any vendor/subcontractor to obtain funds from the State of Arkansas.
<input type="checkbox"/> Required Information Form	This form is utilized by the Trauma Section to complete the grant packet for trauma grant funds. This form is also used as your response to the solicited proposal of providing services to the trauma system.
<input type="checkbox"/> Geographic Coverage Area Form	This form is utilized by the Trauma Section to complete the grant packet for trauma grant funds. If the agency provides service to more than one county, please list the areas covered in alphabetical order.
<input type="checkbox"/> Illegal Immigrant Contractor Disclosure Certification Form	Each agency must submit the illegal immigrant disclosure statement disclosing if you do or do not employ illegal immigrants. Please print the form once it has been submitted and return it with this grant application. If you are a government entity you do not need to submit this disclosure statement.

AASIS Vendor Registrations Instructions

Each trauma grantee needs to obtain (unless they already have one) or update a State vendor number (AASIS Number) by contacting the Office of State Procurement.

To obtain or update a number each potential grantee should fax a W-9 Form to Sheila Kinslow at (501) 324-9311.

You must include a cover sheet with this fax requesting an AASIS Number for grant purposes. The cover sheet must include the name of your agency, mailing address, and telephone number.

Note: The \$25.00 fee will no longer be required, unless you choose to use the Office of State Procurement's website to obtain or update your vendor information.

W-9 Form

A completed w-9 form should be turned in to Sheila Kinslow to receive an AASIS number if a grantee does not already have a number.

Special Note: Please include a w-9 with your facility's Tax ID number. Do not send w-9 forms with personal social security numbers on them.

Form W-9 (Rev. October 2007) Department of the Treasury Internal Revenue Service		Request for Taxpayer Identification Number and Certification		Give form to the requester. Do not send to the IRS.
Name (as shown on your income tax return)				
Business name, if different from above				
Print or type your name on page 2. See Special instructions	Check appropriate box: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D-disregarded entity, C-corporation, P-partnership) ▶ <input type="checkbox"/> Exempt <input type="checkbox"/> Other (see instructions) ▶			<input type="checkbox"/> Exempt payee
	Address (number, street, and apt. or suite no.)			Requester's name and address (optional)
	City, state, and ZIP code			
	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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.				Social security number
Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.				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).				
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 on page 4.				
Sign Here	Signature of U.S. person ▶			Date ▶
General Instructions				
Section references are to the Internal Revenue Code unless otherwise noted.				
Purpose of Form				
A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.				
Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:				
1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),				
2. Certify that you are not subject to backup withholding, or				
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allowable share of any partnership income from				
Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are: • An individual who is a U.S. citizen or U.S. resident alien, • A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, • An estate (other than a foreign estate), or • A domestic trust (as defined in Regulations section 301.7701-7).				
Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.				

Required Information Form

Each applicant must fill out a required information form. This form is your facility's response to the grant proposal.

It is important to include complete information on this form. Items from the required information form will be typed directly into the final grant packet.

Please be sure to include contact information on the person who will be signing the grant. While administrative staff may assist with this process, the required information form should have contact information on the person who will be signing the final grant document.

Please complete the information requested below. This information will be used to develop the grant packet and as the agencies solicited proposal. Please be sure to enter the information as it shows on the State's AASIS Vendor Information. If you need assistance completing this form, please contact the ADH/Trauma Section at (501) 683-0707.

Vendor Information: Hospital EMS

Vendor Name:

Vendor Number: Vendor Tax ID Number:

Physical/Delivery Address:

Vendor City: State: Zip Code - 4:

Vendor P.O. Box:

Vendor P.O. Box City: State: Zip Code - 4:

Vendor Fiscal Year: (Month) to (Month)

Vendor is a: Non-Profit For Profit Government Other:

Contact Information:

Applicants should indicate the contact person who will sign the grant documentation when it is sent to the agency:

Name: Title: Phone Number: ()

E-Mail Address:

Please indicate in the fields below the geographic coverage area alphabetically that your agency covers.

Geographic Coverage Area:

Statewide

One County:

Multiple Counties:

Geographic Coverage Area

The Section of Trauma would like to have all of Arkansas covered by the trauma system.

Please list whether the facility coverage is statewide, county wide, or if your facility covers multiple counties.

Special Note: Please alphabetize when listing multiple county coverage.

Please complete the information requested below. This information will be used to develop the grant packet and as the agencies solicited proposal. Please be sure to enter the information as it shows on the State's AASIS Vendor Information. If you need assistance completing this form, please contact the ADH/Trauma Section at (501) 683-0707.

Vendor Information:

Vendor Name:
Vendor Number: Vendor Tax ID Number:
Physical Delivery Address:
Vendor City: State: Zip Code + 4:
Vendor P.O. Box:
Vendor P.O. Box City: State: Zip Code + 4:
Vendor Fiscal Year: (Month) to (Month)
Vendor is a: Non-Profit For Profit Government Other:

Contact Information:

Applicants should indicate the contact person who will sign the grant documentation when it is sent to the agency:

Name: Title: Phone Number: ()
E-Mail Address:

Please indicate in the fields below the geographic coverage area that your agency covers.

Geographic Coverage Area:

Statewide
 One County:
 Multiple Counties:

Budget Form

A budget form must be completed by each applicant.

The cells in the spreadsheet are set to total each of the categories together. The total amount should equal the funding that your facility is eligible for.

Please figure the category amounts carefully. **It is possible to modify the budget later**, but it will save the applicant time if they are comfortable with the amounts in each category of the budget.

A short **justification** is required for each budget line. This can be as simple as stating that the equipment is being purchased to provide care for trauma patients.

Total Grant Budget Form	
Vendor Name:	
Vendor #:	
Total Sustaining Grant Amount:	
Budget Categories	Amount
Salary	\$0.00
Justification:	
Fringe	\$0.00
Justification:	
Travel	\$0.00
Justification:	
Operations	\$0.00
Justification:	
Equipment/Supplies/Meeting Expenses (Item List below)	\$0.00
Justification:	
Training	\$0.00
Justification:	
Total Direct Cost	\$0.00
Total Budget	\$0.00
as of 5/11/2011	*input values in light blue cells
Equipment/Supplies Total	\$0.00
	Amount
Miscellaneous Equipment (all items under \$25,000.00)	\$0.00
Supplies	\$0.00
Itemized Equipment (Items over \$25,000.00)	\$0.00
	\$0.00

Employment of Illegal Immigrants – Certification by Bidder/Contractor

It is important to certify that facilities do not employ illegal immigrants.

Each applicant can complete this process online. Please be sure to print out the screens and include proof of completion with your grant application.

Applicants who are government entities do not have to fill out this form.

Illegal Immigrant Contractor Disclosure Certification - Instructions

Employment of Illegal Immigrants – Certification by Bidder/Contractor

Pursuant to Act 157 of 2007, all bidders/contractors who will be having a public contract with a state agency for professional services, technical and general services, or any category of constructions in which the total dollar value of the contract is twenty-five thousand dollars (\$25,000) or greater must certify prior to award of the contract that they do not employ or contract with any illegal immigrant(s) in its contract with the State. Bidders shall certify online at:

<https://www.ark.org/dfa/immigrant/index.php?userlogin>

Vendor Name:	This should match the name submitted during the AASIS Vendor Registration process. This should match the name provide to the Office of State Procurement to avoid processing delays.
Contract Type:	Select Technical/General Services
Bid Number:	Leave Blank
Disclosure Statement:	Answer the statement
E-mail Address:	Leave e-mail address of the person signing for the grant.
Select Agency:	Select Department of Health

Click on submit once you are done, this will bring up an overview of the information you just entered. If this information is correct click on **confirm** and submit. Once this is accomplished you have completed the disclosure statement. Click on the print button that is on the top right of the disclosure statement. Submit this print version of your disclosure statement with the grant application.

Employment of Illegal Immigrants – Certification by Bidder/Contractor (Continued)

Arkansas.gov Agencies | Online Services | State Directory A+ | A- | Text | Print

DFA Arkansas Department of Finance and Administration

Home

Contact Us | Live Help

Home Welcome Guest - Login

DFA Illegal Immigrant Contractor Disclosure Certification Login

Agency Login

Username:

Password:

Login

Forget your password? Click here

Vendor Submit Disclosure Form

Are you a vendor and need to submit a disclosure form?

Submit Disclosure Form

Home
Offices
Businesses
Citizens
Government
DFA Employees
News & Events

Online Services
License Plate Renewal
Arkansas Taxpayer Access Point
Arkansas Motor Carrier System
Income Tax Refund Inquiry
Child Support WebPay
Arkansas State Surplus
Child Support Employer Portal

Stay Informed
RSS Feeds

Department of Finance and Administration
1509 West 7th Street
Little Rock, AR 72201
Google Map

Accessibility | Privacy | Security | Acceptable Use

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Click to begin

Employment of Illegal Immigrants – Certification by Bidder/Contractor (Continued)

Home | Contact Us | Live Help

Welcome Guest - Login

DFA Illegal Immigrant Contractor Disclosure Certification Form

Navigation : Home >> Certification Form

Help

Note: *Required fields are marked with an asterisk.

*Vendor Name:

*Contract Type: **Technical/General Services** ▼

Bid Number:

*Disclosure Statement: I do not employ or contract with any illegal immigrant(s).

*E-mail Address:

*Select Agency:

**Subcontractor Information for Procurement Web site,
ACA 19-11-105(e)(1)(B), (e) (2), (e) (3)**
If a contractor uses a subcontractor at the time of certification, the subcontractor shall certify in a manner that does not violate federal law in existence on January 1, 2007, that the subcontractor at the time of certification, does not employ or contract with an illegal immigrant. A sub-contractor shall submit the certification within thirty (30) days after the execution of the subcontract. The contractor shall maintain on file the certification of the subcontractor throughout the duration of the term of the contract.

Home | Online Services | Stay Informed | Department of Finance and Administration

Select Technical Or General Services

Employment of Illegal Immigrants – Certification by Bidder/Contractor (Continued)

Home | Contact Us | Live Help

Welcome Guest - Login

DFA Illegal Immigrant Contractor Disclosure Certification Form

Navigation : Home >> Certification Form

Help

Note: *Required fields are marked with an asterisk.

*Vendor Name:

*Contract Type: Technical/General Services

Bid Number:

*Disclosure Statement: I do not employ or contract with any illegal immigrant(s). True

*E-mail Address:

*Select Agency: Department of Health

Submit

Subcontractor Information for Procurement Web site, ACA 19-11-105(e)(1)(B), (e) (2), (e) (3)
If a contractor uses a subcontractor at the time of certification, the subcontractor shall certify in a manner that does not violate federal law in existence on January 1, 2007, that the subcontractor at the time of certification, does not employ or contract with an illegal immigrant. A sub-contractor shall submit the certification within thirty (30) days after the execution of the subcontract. The contractor shall maintain on file the certification of the subcontractor throughout the duration of the term of the contract.

Mark **“True”**
If you do not
Employ illegal
immigrants

Please be
Sure to select
Department of Health
on the agency drop
down menu

Be sure to press the
**“Confirm and Submit
Button”** on the next page
then print the document
to turn in with the
grant application



★ Complete Grant Packet ★

- Once all of the documents are completed, please send them by Fed Ex, UPS, or similar carrier to:

**Arkansas Department of Health
Trauma Section
4815 West Markham, Slot 4
Little Rock, AR 72205-3867**

Sub Grant Agreement Page

The application will be used to create a grant packet. This packet will be returned for final signatures once it has been processed.

When the packet is sent to the grantee by Fed Ex, UPS, or similar carrier pages that require signatures or spaces that need to be filled out will be tabbed.

Agreement # _____

ARKANSAS DEPARTMENT OF HEALTH
SUB-GRANT AGREEMENT

XI. Certification and Signature

A. Recipient Certification of Documentation: The Recipient certifies that all documentation presented to obtain this sub-grant is true and complete. The Recipient agrees to notify the Department of any changes in this documentation except when the Department has given specific written permission to waive such notification.

B. SIGNATURES:

Signature of Sub-Grant Recipient Authorized Representative	
Signature of Recipient Authorized Representative	Date
Printed Name of Recipient Authorized Representative	Title
In signing this document, I attest that I am authorized by the Board of Directors or other governing authority to sign this sub-grant on behalf of the Recipient. This sub-grant is effective on date specified on page 1, but no earlier than the date signed by the last signing party.	

Signature of ADH Agency Authorized Representative	
Signature of ADH Agency Authorized Representative	Date
Robert S. Bennett	CFO
Printed Name of ADH Agency Authorized Representative	Title
In signing this document, I attest I am exercising appropriate fiduciary authority in the commitment of available resources to achieve program agency objectives.	



Sign in
Blue Ink

Date

Contract and Grant Disclosure and Certification Form

Check “Yes” or “No” to indicate if your facility will subcontract with another vendor to expend the grant funding for you. If the answer is “Yes” please list the subcontractor’s name

For Individuals: Fill in spaces if the person filling out the grant is a member of the General Assembly, Constitutional Officer, State Employee, or if they serve on a state board or commission. Otherwise mark “None of the Above Applies”

For a Vendor (Business): Fill out this portion if a member of your management team/board holds any of these positions or mark “None of the Above Applies”

Please put an “X” in the box for services

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: Yes No

TAXPAYER ID NAME: Goods? Services? Both?

YOUR LAST NAME: FIRST NAME: M.I.:

ADDRESS:

CITY: STATE: ZIP CODE: COUNTRY: USA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

For Individuals *

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (✓)		Name of Position of Job Held <small>[§ 8-2-2(a), representative name of board/ commission, data entry, etc.]</small>	For How Long?		What is the person(s) name and how are they related to you? <small>[i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]</small>	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Constitutional Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
State Board or Commission Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
State Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> None of the above applies							

For a Vendor (Business) *

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (✓)		Name of Position of Job Held <small>[§ 8-2-2(a), representative name of board/ commission, data entry, etc.]</small>	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Constitutional Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
State Board or Commission Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
State Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> None of the above applies								

Please remember to fill out the Percentage % of ownership interest for any members listed

Contract and Grant Disclosure and Certification Form – Page 2

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete and submit a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:
Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.
3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature _____ Title _____ Date _____
Vendor Contact Person _____ Title _____ Phone No. _____

Agency Use only

Agency Number 0645 Agency Name Arkansas Department of Health Agency Contact Person Sherry Gibson Contact Phone No. 501-661-2569 Contract or Grant No.

If the grantee is using a subcontractor to fulfill the obligations of this grant, they must have them fill out a Contract and Grant Disclosure and Certification Form as well.

A signature in Blue Ink, Title, and Date are required. The "Contact Person" may be the same as the person signing the form.

Certification Regarding Lobbying

Each grantee must certify whether they employ a professional lobbyist or pay a group to lobby for their facility.

Please be sure to fill out all spaces on these forms.

Spaces left blank or improperly filled out can delay the processing of the grant packet.

Agreement #	
Attachment #	3 Action New

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature of Authorized Recipient Representative _____
Date

Name of Recipient Agency

Trauma Hospital Sustaining Grant

Title of Grant Program

Sign in
Blue Ink

Date



Certification Regarding Lobbying – Page 2

The second page of the Certification Regarding Lobbying form provides spaces for the grantee to indicate lobbying activities.

If the grantee does not lobby, they can put **N/A** in each of these boxes.

Please Note: do not put **N/A** in one box and scratch through the rest. It is important to indicate that each box does not apply to the facility.

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: small;">Agreement #</td> <td style="width: 50px;"></td> </tr> <tr> <td style="font-size: small;">Attachment #</td> <td style="text-align: center;">8</td> </tr> <tr> <td style="font-size: small;">Page</td> <td style="text-align: center;">1 of 2</td> </tr> </table>	Agreement #		Attachment #	8	Page	1 of 2	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: small;">Action</td> <td style="width: 50px;">New</td> </tr> </table>	Action	New	<p style="text-align: right; font-size: small;">Approved by OMB 0348-0046</p> <p style="text-align: center;">Disclosure of Lobbying Activities Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352 (See reverse for public burden disclosure)</p>
Agreement #										
Attachment #	8									
Page	1 of 2									
Action	New									
<p>1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance</p>	<p>2. Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award</p>	<p>3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change</p> <p>For material change only: Year _____ quarter _____ Date of last report _____</p>								
<p>4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if Known:</p> <p style="text-align: center; font-size: small;">Congressional District, if known:</p>	<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> <p style="text-align: center; font-size: small;">Congressional District, if known:</p>									
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description:</p> <p style="font-size: small;">CFDA Number, if applicable: _____</p>									
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known: \$ _____</p>									
<p>10. a. Name and Address of Lobbying Registrant <i>(if individual, last name, first name, MI):</i></p>	<p>b. Individuals Performing Services <i>(including address if different from No. 10a)</i> <i>(last name, first name, MI):</i></p>									
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>										
<p>Federal Use Only</p>										
<p>Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____</p> <p style="font-size: x-small;">Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)</p>										

Please mark **N/A** in each of these boxes if your facility does not lobby

Sign in Blue Ink and fill out

Certification Regarding Lobbying – Page 3

The second page of the Certification Regarding Lobbying form provides spaces for the grantee to indicate lobbying activities.

If the grantee does not lobby, they can put **N/A** in each of these boxes.

Please do not put **N/A** in one box and scratch through the rest. It is important to indicate that each box does not apply to the facility.

Agreement #	
Attachment #	3
Action	New
Page	2 of 2

CONTINUATION SHEET
Approved by OMB

DISCLOSURE OF LOBBYING ACTIVITIES

Reporting Entity

Authorized for Local Reproduction
Standard Form--LLL-A

This space should be used to list the name of your facility.

Additional space to list lobbying activities

Business Associate Agreement

It is important to read through the four pages of the Business Associate Agreement before signing in blue ink.

Once the grantee has completed the review, signed and dated the document, it is important to return the entire original packet to the Trauma Section.

Once received and reviewed, a purchase order will be created which will allow the grantee to invoice for grant funding.

Agreement #	
Attachment #	4 Action New

(2) Immediately terminate this Agreement and the contract between the ADH and Business Associate if Business Associate has breached a material term of this Agreement and cure is not possible; or

(3) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon written notice to the Director of the ADH that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

8. Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(c) Survival. The respective rights and obligations of Business Associate under "Effect of Termination" of this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

9. Signatures

Signature of Business Associate Authorized Representative	Date
Printed Name of Business Associate Authorized Representative	Title
Signature ADH Program Authorized Representative	Date
Robert S. Bennett	CFO
Printed Name of ADH Program Authorized Representative	Title

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Sign in Blue Ink

Date



Signed Grant Packet



- Once all of the documents are signed and completed, please send them by Fed Ex, UPS, or similar carrier to:

Arkansas Department of Health

Trauma Section

4815 West Markham, Slot 4

Little Rock, AR 72205-3867

Reimbursement Request/Invoice

The award period should match the start and end dates on the purchase order

After the grant packet is reviewed a purchase order and fully executed copy of the grant will be sent to the grantee.

Following the receipt of the purchase order, the grantee can expend funds and send in request(s) for reimbursement on the state form.

The best practice is to spend all of the funding before sending in a request for reimbursement. If this is not possible the grantee can send in a request once per month.

ARKANSAS DEPARTMENT OF HEALTH SUBGRANTEE PAYMENT REQUEST FORM						
AWARD PERIOD:	AGENCY CENTER/BRANCH /SEC					
AWARD AMOUNT:	CFDA #:	CFDA TITLE:				
Request Period:	E.I.M. (Tax ID #):					
Subgrantee Name:				Telephone #:		
Mailing Address:	# Street Address		City	State	Zip	
Budget Categories	Requested Budget	APPROVED BUDGET	Previous Expenditures	Expenditures This Period	Total Expenditures	Remaining Budget
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-
* Must include all proposed equipment acquisitions of \$2,500 or greater and submit capital equipment inventory form.						
CASH RECONCILIATION (This award only)			SUMMARY			
+Collected Fees to date (if applicable):	\$	-	+Subgrant Award:	\$		0.00
+Received Funds to date:	0.00	Advanced Funds (If approved):	\$		-	Amount of this Request
+Prior Funds requested not received:	0.00	Previous Expenditures	\$		-	
Total Expenditures	0.00	-Total Disbursed & on Hand:	0.00			
Expenditures this period (Amt. Of Request):	0.00	Remaining Award Prior to Request:	\$		-	
Total Funds Disbursed & on Hand:	0.00	Remaining Award after request:	\$		-	\$ -
On behalf of the subgrantees listed above, I certify that the items for which payment is claimed were furnished under the authority of the law and in accordance with the terms of our grant with the Arkansas Department of Health and that the charges are reasonable, proper, and this claim has not been paid in full.						
Signature:				Date:		
Printed Name & Title:				Contact Phone #:		
ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY						
VENDOR #:			OUTLINE AGREEMENT #:			
PO #:			GOODS RECEIPT #:			
DIRECT DEPOSIT	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
REVIEWED & APPROVED BY:						
Signature:				Date:		
Printed Name & Title:				Contact Phone #:		

Reimbursement Request/Invoice

Please enter the Award Amount in dollars and cents – For example: \$12,740.00

The Request Period should be the start date on the purchase order till the date you send in the request

ARKANSAS DEPARTMENT OF HEALTH SUBGRANTEE PAYMENT REQUEST FORM				
AWARD PERIOD:	AGENCY CENTER/BRANCH /SEC			
AWARD AMOUNT:	CFDA #:		CFDA TITLE:	
Request Period:	E.I.N. (Tax ID #):			
Subgrantee Name:				Telephone #:
Mailing Address:				
	# Street Address	City	State	Zip

The Subgrantee Name should match the name in the state vendor (AASIS) system

Reimbursement Request/Invoice

The Requested Budget and the Approved Budget should match the amount listed in the purchase order and final grant copy budget

	# Street Address		City		State	Zip
Budget Categories	Requested Budget	APPROVED BUDGET	Previous Expenditures	Expenditures This Period	Total Expenditures	Remaining Budget
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-

* Must include all proposed equipment acquisitions of \$2,500 or greater and submit capital equipment inventory form.

The Expenditures This Period can be for the total grant award or a portion of the grant award

If the grantee is only requesting a portion of the grant under Expenditures This Period, then there should be figures in the Remaining Budget column

Reimbursement Request/Invoice

The total of the amounts on page two of the form should be entered in the “Other” category on the first page of the form.

# Street Address			City		State	Zip
Budget Categories	Requested Budget	APPROVED BUDGET	Previous Expenditures	Expenditures This Period	Total Expenditures	Remaining Budget
Regular Salary	-	-	-	-	-	-
Fringe	-	-	-	-	-	-
Travel	-	-	-	-	-	-
M & O	-	-	-	-	-	-
Other (bring forward from Page 2)	-	-	-	-	-	-
Sub-Total	-	-	-	-	-	-
*Capital	-	-	-	-	-	-
Indirect Cost	-	-	-	-	-	-
Collected Fees	-	-	-	-	-	-
Total	-	-	-	-	-	-

* Must include all proposed equipment acquisitions of \$2,500 or greater and submit capital equipment inventory form.

The Requested Budget, Approved Budget, Expenditures This Period, Total Expenditures, and Remaining Budget should be filled out in “Other” on page one if amounts are entered on page two

Reimbursement Request/Invoice

If a grantee is requesting the entire grant amount, there should not be any figures listed in the Remaining Award after request box.

If figures are entered correctly in all of the columns, the Amount of this Request should be filled in automatically

Please be sure to sign in Blue Ink, date, include a printed name and title along with a phone number on these lines.

* Must include all proposed equipment acquisitions of \$2,500 or greater and submit capital equipment inventory form.			
CASH RECONCILIATION (This award only)		SUMMARY	
+Collected Fees to date (if applicable):	\$ -	+Subgrant Award:	\$0.00
+Received Funds to date:	0.00	Advanced Funds (if approved):	\$ -
+Prior Funds requested not received:	0.00	Previous Expenditures	\$ -
Total Expenditures	0.00	-Total Disbursed & on Hand:	0.00
Expenditures this period (Amt. Of Request):	0.00	Remaining Award Prior to Request:	-
Total Funds Disbursed & on Hand:	0.00	Remaining Award after request:	\$ -
On behalf of the subgrantee listed above, I certify that the items for which payment is claimed were furnished under the authority of the law and in accordance with the terms of our grant with the Arkansas Department of Health and that the charges are reasonable, proper, and this claim has not been paid in full.			
Signature:		Date:	
Printed Name & Title:		Contact Phone #:	
ARKANSAS DEPARTMENT of HEALTH PERSONNEL USE ONLY			
VENDOR #:		OUTLINE AGREEMENT #:	
PO #:		GOODS RECEIPT #:	
DIRECT DEPOSIT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
REVIEWED & APPROVED BY:			
Signature:		Date:	
Printed Name & Title:		Contact Phone #:	

This section is for Arkansas Department of Health Personnel Use Only

Closeout Form

The grant period should match the start and end dates on the purchase order

Each grantee must complete a closeout form each year to closeout their trauma grant.

The approved budget amounts and the total amount invoiced should be entered. Since the sustaining grants are based on reimbursement, these amounts might be below the budgeted figure. Please do not exceed the budget amounts on this page of the closeout form.

Grant Period:	<input type="text"/>	to	<input type="text"/>
Sub-grantee Name:	<input type="text"/>		
Mailing Address:	<input type="text"/>		
City:	<input type="text"/>		
State:	<input type="text"/>		
Zip Code:	<input type="text"/>		
E.I.N. (Tax ID #)	<input type="text"/>		
AASIS Vendor Number:	<input type="text"/>		

Instructions: Please list the amount of the grant award broken down by categories in the approved budget column below. The total amount invoiced **cannot** exceed the approved budget amount for the grant. Any additional expenditures may be described in the narrative.

Budget Categories	Approved Budget	Total Amount Invoiced
Personnel	\$ <input type="text"/>	\$ <input type="text"/>
Trammg	\$ <input type="text"/>	\$ <input type="text"/>
Operations	\$ <input type="text"/>	\$ <input type="text"/>
Facilities Equipment	\$ <input type="text"/>	\$ <input type="text"/>
Total:	\$ <input type="text"/>	\$ <input type="text"/>

ADH Use Only	
Date Reviewed:	<input type="text"/>
Date Approved:	<input type="text"/>
Date Scanned:	<input type="text"/>
Date Input in Database:	<input type="text"/>
Other:	<input type="text"/>
Initials:	<input type="text"/>

Closeout Form – Page 2

The narrative report should describe the amounts expended on the service's trauma program during the grant year. This amount may exceed the budget of the grant.

Please be sure to provide a printed name, date, signature in Blue Ink, and a phone number.

The image shows a screenshot of a form titled "Narrative Report on Expenditures". The form has a large white area for the narrative report. Below this area are four fields for personal information: "Print Name", "Date", "Signature (must use blue ink)", and "Phone Number". At the bottom of the form, there is a footer with the text "TS – Sub-Grant 01 (Revised 3/31/2011)" on the left and "Page 3" on the right. Two red arrows are overlaid on the image: one points from the text on the left to the top-left corner of the narrative report area, and the other points from the text on the left to the signature line.

Narrative Report on Expenditures

Print Name _____

Date _____

Signature (must use blue ink) _____

()
Phone Number _____



Completed Grant Year



- Once the closeout form is completed and all invoices and proof of expenditures are attached, please send them to:

Arkansas Department of Health

Trauma Section

4815 West Markham, Slot 4

Little Rock, AR 72205-3867

- Once this process is complete, your service has finished the grant year and is ready for the next funding period.