



QUAY COUNTY GOVERNMENT  
300 South Third Street  
P.O. Box 1246  
Tucumcari, NM 88401  
Phone: (575) 461-2112  
Fax: (575) 461-6208

AGENDA  
REGULAR SESSION  
QUAY COUNTY BOARD OF COMMISSIONERS  
JANUARY 7, 2019

---

**9:00 A.M. Call Meeting to Order**

Pledge of Allegiance

Approval of Minutes-Regular Session December 10, 2018

Approval/Amendment of Agenda

**Public Comment**

**Ongoing Business**

**New Business**

**I. Quay County Board of Commissioners**

A. Election of Chairman

B. Request Approval of 2019 Reorganization of the Board Appointments and Sub-Committees

C. Distribution of Financial Interest Disclosure Forms

D. Request Approval of FY 2018-2019 Resolution No. 15

- Adopting Procedures for Compliance in Accordance with NMSA 10-17; and
- Miscellaneous Provisions that Documents that Annual Audits, Summary Minutes, Monthly Budget, Financial Reports, and Monthly Warrants List are Public Information and Establishes Method of Compliance with Revenue and Expenditure Requirements

**II. C. Renee Hayoz, Presbyterian Medical Services, Administrator**

- Presentation of Monthly RPHCA Reports

**III. Tim Clark, Tucumcari High School (THS) Class of 2020**

- Request Approval to Waive all Fees for THS Prom Events at QC Fairgrounds

**IV. Russell Shafer, Quay County Sheriff**

- Presentation of Sheriff's Report

**V. Donald Adams, Quay County Fire Marshal**

- Request Approval of EMS Fund Act FY 2020 Application - Fire District 1
- Request Approval of EMS Fund Act FY 2020 Application - Quay Fire
- Request Approval of EMS Fund Act FY 2020 Application - Bard-Endee Fire
- Request Approval of EMS Fund Act FY 2020 Application - Forrest Fire



DOC #CM-00457

01/28/2019 01:05 PM Doc Type: COCOM

Fee (No FieldTag Finance TotalFees found)

Quay County, NM

Ellen White - County Clerk

Pages: 108



County Clerk, County Cle

- VI. Darla Munsell, CDBG Coordinator**
- Request Approval of **NM DFA Local Government Division CDBG Program Grant Agreement Project No. 18-C-RS-I-01-G-02**
- VII. Larry Moore, Quay County Road Superintendent**
- **Road Update**
- VIII. Richard Primrose, Quay County Manager**
- Request Approval of the **Quay County Comprehensive Plan**
  - Request Approval of the **Asset Management Policy**
  - **Correspondence**
- IX. Request Approval of Accounts Payable**
- X. Other Quay County Business That May Arise During the Commission Meeting and/or Comments from the Commissioners**
- XI. Request for Closed Executive Session**
- Pursuant to Section 10-15-1(H) 7. **The New Mexico Open Meetings Act Pertaining to Threatened or Pending Litigation**
- XII. Franklin McCasland, Quay County Commission Chairman**
- Proposed action, if any, from Executive Session

**Adjourn**

*Lunch-Time and Location to be Announced*

## REGULAR SESSION-BOARD OF QUAY COUNTY COMMISSIONERS

January 7, 2019

9:00 A.M.

BE IT REMEMBERED THE HONORABLE BOARD OF QUAY COUNTY COMMISSIONERS met in regular session the 7th day of January, 2019 at 9:00 a.m. in the Quay County Commission Chambers, Tucumcari, New Mexico, for the purpose of taking care of any business that may come before them.

### PRESENT & PRESIDING:

Franklin McCasland, Chairman  
Mike Cherry, Member  
Sue Dowell, Member  
Ellen L. White, County Clerk  
Richard Primrose, County Manager

### OTHERS PRESENT:

Larry Moore, Quay County Road Superintendent  
Janie Hoffman, Quay County Assessor  
Daniel Zamora, Quay County Emergency Management  
Russell Shafer, Quay County Sheriff  
Renee Hayoz, Presbyterian Medical Services Administrator  
Gail Houser, Tucumcari MainStreet Director  
Patsy Gresham, Quay County Treasurer  
J. D McEwen, Resident  
Donald Adams, Quay County Fire Marshal  
Darla Munsell, Quay County CDBG Coordinator  
Tim Clark, THS Junior Class Sponsor, Aaliyah Brown and A'Leaya Lucero, THS  
Junior Class Representatives  
Ron Warnick, Quay County Sun  
Cheryl Simpson, Quay County Manager's Office

Chairman McCasland called the meeting to order. Aaliyah Brown led the Pledge of Allegiance.

A MOTION was made by Sue Dowell, SECONDED by Mike Cherry to approve the minutes from the December 10, 2018 regular session as presented. MOTION carried with Cherry voting "aye", Dowell voting "aye" and McCasland voting "aye".

A MOTION was made by Sue Dowell, SECONDED by Mike Cherry to approve the agenda after amending by moving Item No. 3 to No. 1. MOTION carried with Cherry voting "aye", Dowell voting "aye" and McCasland voting "aye".

PUBLIC COMMENTS: Donald Adams, Quay County Fire Marshal, commended Daniel Zamora for his excellent coordination of the weather emergency on December 27<sup>th</sup> that led to 300 stranded motorists being fed and sheltered. The Commissioners echoed the comments.

Those mentioned that lent a hand included the First Baptist Church, Fire Departments, Knights of Columbus and the many citizens that stepped up with food, funds and other supplies.

ONGOING BUSINESS: NONE

NEW BUSINESS:

Tim Clark, THS Junior Class Sponsor introduced Aaliyah Brown and A'Leaya Lucero, THS Junior Class Representatives who requested use of the Quay County Exhibit Center for the 2019 Prom at no cost to the class. Clark stated they have read the agreement and understand the terms that must be met in order to have fees waived. A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to approve the request. MOTION carried with Cherry voting "aye", Dowell voting "aye" and McCasland voting "aye".

Chairman McCasland requested nominations for Election of Chairman for the 2019 calendar year. A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to nominate and elect Commissioner Franklin McCasland as Chairman of the Board of Quay County Commissioners. MOTION carried with Dowell voting "aye", Cherry voting "aye" and McCasland voting "aye".

Chairman McCasland presented the 2019 Board Appointments and Sub-Committee Appointments that need to be filled. A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to approve the Appointments as attached to these minutes with changes for 2019. MOTION carried with Dowell voting "aye", Cherry voting "aye" and McCasland voting "aye".

County Clerk Ellen White reported all Financial Statements, as required by law, have been distributed to all Elected Officials and Quay County Government Staff.

Chairman McCasland presented Resolution No. 15; Adopting Procedures for Compliance in Accordance with NMSA 10-17; and Miscellaneous Provisions that documents that Annual Audits, Summary Minutes, Monthly Budget, Financial Reports and Monthly Warrant Lists are Public Information and Establishes Method of Compliance with Revenue Expenditure A MOTION was made Mike Cherry and SECONDED by Sue Dowell to approve Resolution No. 15 as presented. MOTION carried with Cherry voting "aye", Dowell voting "aye" and McCasland voting "aye". A copy of said Resolution is attached and made a part of these minutes.

Commissioner Dowell took a moment to explain to the public in attendance the procedures for requesting a copy of the recorded tape from Commission Meetings through the Inspection of Public Records Act.

Renee Hayoz, Presbyterian Medical Services Administrator presented the monthly RPHCA Report ending November 30<sup>th</sup>, 2018. A copy of said Report is attached to these minutes.

Russell Shafer, Quay County Sheriff presented monthly activity reports from his Department for November and December, 2018. Copies of those reports are attached.

Donald Adams, Quay County Fire Marshal presented the annual EMS Fund Act 2020 Applications on behalf of Fire District 1, Quay Fire and Bard-Endee Fire Departments. Primrose

stated in addition to those three departments, Forrest Fire Department submitted theirs today by email, incomplete.

A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to approve the Applications for Fire District 1, Quay Fire and Bard-Endee Fire Departments. MOTION carried with Cherry voting "aye", Dowell voting "aye" and McCasland voting "aye". Copies are attached to these minutes.

A MOTION was made by Mike Cherry to table the Application for Forrest Fire Department until the proper documents are submitted. MOTION died for lack of a SECOND.

Commissioner Dowell stated she hated to see a portion of the County be without the services this funding might provide because of the lack of proper signatures. Primrose stated the department has until January 25 to submit the completed paperwork, however if it's postponed the Commission will have to have a special meeting to approve the application. McCasland agreed with Dowell regarding concern for lack of funding for the citizens who are served by the Forrest Fire Department. A MOTION was made by Dowell and SECONDED McCasland to approve the application pending the completed application and required signatures. MOTION carried with Dowell voting "aye", McCasland voting "aye" and Cherry voting "no". A copy of the completed application has since been submitted and is attached to these minutes.

Darla Munsell, Quay County CDBG Coordinator requested approval of the Grant Agreement for Project No. 18-C-RS-I-01-G-02 (Quay Road AR). The project includes the Grant awarded in the amount of \$750,000.00 plus the county match of \$22,500.00. A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to approve the Agreement. MOTION carried with Dowell voting "aye", McCasland voting "aye" and Cherry voting "aye". A copy is attached to these minutes.

Larry Moore, Quay County Road Superintendent presented the following road updates:

1. Blade Reports for December were distributed.
2. The request for donation of millings from the State Highway Department has been rejected due to the change in administration. Moore stated even though the previous administration approved it, the necessary paperwork was not completed by the State to be able to receive the millings.
3. As a result of not receiving the millings to begin the School Bus Projects in San Jon, the crews will begin the Co-Op Projects in the area of Quay Road AD.
4. Received Letter of Intent for the 2019-2020 LGRF Projects.
5. Received letter requesting submission of the 2019 Certified Maintained Road Map and listing with an April 1, 2019 deadline.
6. The crews from the Casa Mesa Wind Project left materials in the area and donated them for use on roads. The crews used those on Quay Road 24. In addition, a letter signing off that roads are in good repair following that project was submitted to Moore. Moore inspected the roadways and reported they were repaired and approved.

Richard Primrose, Quay County Manager presented the following items for approval:

1. 2018 Updated Quay County Comprehensive Plan. Commissioner Dowell stated she is impressed with the Plan, but would like to stress the importance of being aggressive with

the items to help Quay County move forward. Dowell stated it was important to figure out how to implement portions of the plan annually. A MOTION was made by Sue Dowell, SECONDED by Mike Cherry to approve the 2018 Comprehensive Plan. MOTION carried with Dowell voting "aye", Cherry voting "aye" and McCasland voting "aye".

2. Quay County Asset Management Phase 1. Primrose stated this is a working document, and will continue to be updated periodically until it's complete. A MOTION was made by Sue Dowell, SECONDED by Mike Cherry to approve Phase 1 of the Asset Management Plan. MOTION carried with Dowell voting "aye", Cherry voting "aye" and McCasland voting "aye".

Copies of both the Comprehensive Plan and the Asset Management Plan can be reviewed in the Office of the County Clerk or the Manager's Office.

Primrose presented the following correspondence:

1. Distributed the monthly Gross Receipts Tax Report.
2. The New Mexico Counties Legislative Conference is slated for January 15-18 in Santa Fe.
3. The Greater Tucumcari EDC will host the annual Quay Day Breakfast on Wednesday, January 16 at 6:30 a.m. at the Inn of Loretto in Santa Fe. All legislators and several cabinet secretaries will be in attendance.

#### ACCOUNTS PAYABLE:

A MOTION was made by Mike Cherry SECONDED by Sue Dowell to approve the expenditures included in the Accounts Payable Report ending December 31, 2018. MOTION carried with Dowell voting "aye", Cherry voting "aye" and McCasland voting "aye".

Other Quay County Business That May Arise During the Commission Meeting and/or comments from the Commissioners:

Chairman McCasland asked if anyone had seen any new cabinet appointments by the Governor that will affect Quay County. Moore stated a new Transportation Secretary had been appointed.

Ellen White, Quay County Clerk informed everyone that ballots for the Tucumcari Public School District should be arriving in mail boxes this week.

Chairman McCasland requested a ten minute break. Time noted: 9:55 a.m.

Return to regular session. Time noted 10:00 a.m.

A MOTION was made by Mike Cherry, SECONDED by Sue Dowell to go into Executive Session pursuant to the Open Meetings Act pursuant to Section 10-15-1(H)7 to discuss Threatened or Pending Litigation. MOTION carried with Cherry voting "aye", McCasland voting "aye" and Dowell voting "aye".

Time noted 10:01 a.m.

-----EXECUTIVE SESSION-----

Return to regular session. Time noted 10:55 a.m.

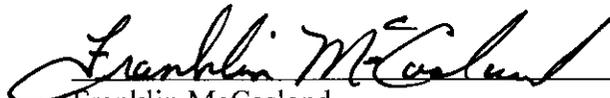
A MOTION was made by Mike Cherry, SECONDED by Sue Dowell stating only Threatened or Pending Litigation was discussed during Executive Session. MOTION carried with Cherry voting "aye", McCasland voting "aye" and Dowell voting "aye".

NO ACTION WAS TAKEN FOLLOWING EXECUTIVE SESSION.

There being no further business, a MOTION was made by Sue Dowell SECONDED by Mike Cherry to adjourn. MOTION carried with McCasland voting "aye", Cherry voting "aye" and Dowell voting "aye". Time noted 11:00 a.m.

Respectfully submitted by Ellen White, County Clerk.

BOARD OF QUAY COUNTY COMMISSIONERS

A circular official seal of Quay County, Oregon, is located on the left side of the page. The seal contains the text "OFFICIAL SEAL", "QUAY COUNTY, OREGON", and "JANUARY 1852".  
  
Franklin McCasland

  
Sue Dowell

  
Mike Cherry

ATTEST:

  
Ellen L. White, County Clerk

**BOARD APPOINTMENTS  
JANUARY 7, 2019**

NMAC Multi-Line Pool.....	Richard Primrose/Mike Cherry Alternate
NMAC Board of Directors Member .....	Mike Cherry
NMAC Workers Comp Pool.....	Mike Cherry/Richard Primrose Alternate
Tucumcari Economic Development Board.....	Franklin McCasland/Mike Cherry, Alternate
City of Tucumcari Library Board .....	Alida Brown
Llano Estacado RC&D .....	Franklin McCasland/Sue Dowell, Alternate
Northeast Regional Transportation.....	Larry Moore/Richard Primrose, Alternate
E-911 County Coordinator.....	Daniel Zamora/ Robert McClelland, Alternate
Quay County Fair Board.....	Sue Dowell/Franklin McCasland, Alternate
MCCH Council Liaison .....	Russell Shafer/Dennis Garcia, Alternate
Ute Reservoir Water Commission .....	Richard Primrose/Franklin McCasland Alternate
Natural Resources Committee .....	Bill Humphries
TQCRWA .....	Richard Primrose/Franklin McCasland, Alternate
EPCOG .....	Richard Primrose/Mike Cherry, Alternate
Tucumcari/Quay County Regional Emergency Communication Center .....	Richard Primrose/Mike Cherry, Alternate
Quay County Finance Committee.....	Ex Officio Members: Franklin McCasland Mike Cherry Sue Dowell Ellen White Richard Primrose/Patsy Gresham/Cheryl Simpson



QUAY COUNTY  
FY 2018-2019 RESOLUTION No. 15

**A RESOLUTION ADOPTING PROCEDURES FOR COMPLIANCE  
IN ACCORDANCE WITH NMSA 10-17; MISCELLANEOUS PROVISIONS**

**WHEREAS**, the County Commission is required to have summary minutes prepared and available for public inspection immediately following the end of a commission meeting approving said minutes; and

**WHEREAS**, the County Clerk may use recorders to record all or a portion of a County Commission Meeting; and

**WHEREAS**, tapes may be used by the Clerk as a tool for transcribing the minutes, any tape recording of a commission meeting will be held as public record and subject to inspection at the office of the County Clerk for two weeks and will then be erased; and

**WHEREAS**, annual audits, the monthly budget and financial reports including the monthly list of checks shall be made available to the public, establishing the method of compliance with revenue and expenditure requirements.

**NOW THEREFORE, BE IT RESOLVED AND ORDERED:**

1. The County has adopted this Resolution establishing compliance with NMSA 10-17; and
2. All reports shall be made available for public inspection and review in accordance with the Inspection of Public Records Act, NMSA 14-2.

**PASSED, APPROVED AND ADOPTED** by the governing body at its meeting on January 7, 2019.

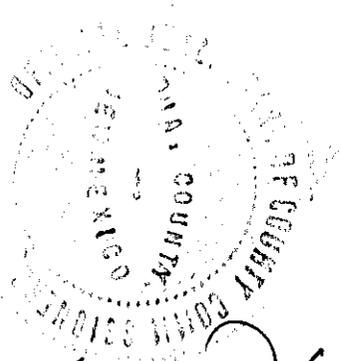
**QUAY COUNTY COMMISSIONERS**

  
Franklin McCasland, Commissioner

  
Sue Dowell, Commissioner

  
Mike Cherry, Commissioner

Attest:   
Ellen White, County Clerk



**Clinic/Program Name:** Quay County Family Health Center  
**Month Reported:** November 2018

**Monthly RPHCA Narrative Report**

*Please provide brief but detailed information for the following questions. Answer all questions or mark N/A.*

- 1. Please describe any changes in the types of services provided during the month reported. Describe any discussions about adding new services**

No changes in type of services provided for the month of November.

- 2. Please describe any difficulties encountered in providing services during the month reported. What were the causes of the difficulties?**

None.

- 3. Were there any changes in the encounters (+ or - 10%) from the previous month reported? Please explain any causes for the changes.**

Encounters have increased about 15% due to the new provider starting to see patients.

- 4. Please describe any changes in the staffing pattern (regardless of the position or the change in FTE).**

None. We are fully staffed.

- 5. Please describe recruitment efforts for any positions. Which positions? What actions have been taken?**

All positions have been filled.

- 6. Were there any changes to the hours? Explain.**

No changes were made. Hours continue to be 7:00 AM – 5:30 PM, Monday through Friday.

- 7. What efforts did you make to collaborate with local and statewide entities?**

- Quay County Health Council meeting was attended on 11/8/18
- VFC Coordinator met with MA regarding vaccines.
- Advisory meeting was held on 11/20/18
- Quay Co Commissioner Meeting was held on 11/26/18

8. **Please describe any methods for increasing clinic utilization that your program and staff are engaging in.**

Site continues to provide care at the Quay County Detention Center.

9. **Please describe the outreach activities your program and staff provided to the community during the month reported.**

- The Senior Centers in the communities of House, San Jon and Tucumcari were visited and senior services were provided.
- Diabetic Retinopathy Screening was held on 11/14/18. There were over 30 kept appointments.
- 

10. **Have you received any new funding? Are you aware of any new funding opportunities? Please describe any new initiatives or projects that have been implemented.**

None at this time.

**Please note the date of the last advisory board meeting AND THE AGENDA ITEMS DISCUSSED.**

Meeting was held on November 20, 2018

PMS Board Report  
Recruitment of New Members  
Regional Goals  
Clinic Update  
Home Visiting Update

**RPHCA Program**  
**Monthly Level of Operations Form**

revised 7/7/15

<b>Organization Name: Presbyterian Medical Services</b>		<b>Contract #</b>	18774	
<b>Reporting Site: Quay County Family Health Center</b>		<b>Report Month/Year:</b>	11/01/18	
<b>Action Plan Item</b>		<b>Actual Monthly Level</b>		
<b>Level of Operations</b>	Total Number of Primary Care Encounters		370	
	By Provider Type:			
	Physician Encounters		5	
	Midlevel Practitioner Encounters		365	
	Dentist Encounters			
	Dental Hygienist Encounters			
	Behavioral Health Encounters			
	All Other Licensed/Certified Provider Encounters			
	By Payment Source:			
	Sliding Fee Encounters - Medical/Behavioral Health		23	
	Sliding Fee Encounters - Dental			
	Medicaid Encounters - Medical/Behavioral Health		102	
	Medicaid Encounters - Dental			
	County Indigent Encounters			
	Other 3 <sup>rd</sup> Party Encounters		96	
Medicare Encounters		96		
100% Self Pay (non-discounted/non-3 <sup>rd</sup> party) Encounters		3		
<b>Unduplicated Number of Users</b>	Total # of unduplicated users		60	
	At or Below Poverty		40	
	Between Poverty and 200% of Poverty		19	
	Above 200% of Poverty		1	
<b>Staffing Level</b>	Administrative Staff		3.2	
		Clinical FTEs		
		Admin FTEs		
	Physicians		0.05	
	Certified Nurse Practitioners		2	
	Physician Assistants			
	Certified Nurse Midwives			
	Dentists			
	Dental Hygienists			
	Behavioral Health Professionals			
	Community Health Workers			
Clinical Support Staff		2.2		
All Other Staff		3.7		
<b>Prior Month's Primary Care Financial Information</b>	<b>Please enter the month being reported: June</b>			
	Total Primary Care Revenues - all sources		58,073	
	Sliding Fee Revenues - Medical		3,612	
	Sliding Fee Revenues - Dental		0	
	Medicaid Revenues - Medical		15,507	
	Medicaid Revenues - Dental		0	
	County Indigent Fund Revenues		0	
	Other 3 <sup>rd</sup> Party Revenues		4,545	
	Medicare Revenues		9,833	
	100% Self Pay (non-discounted/non-3 <sup>rd</sup> party) Patient Revenues		190	
	Contracts/Grants Revenues (including RPHCA)		24,386	
	Total Primary Care Expenditures		72,418	
	Total Primary Care Charges		59,600	
Sliding Fee Discounts - Medical		7,104		
Sliding Fee Discounts - Dental		0		
Prepared by: C Renee Hayoz		12/14/2018		

November 30, 2018

Quay County Sheriff's Office monthly report.

Calls for Service

Month Reported	Count
January	87
February	76
March	120
April	109
May	116
June	101
July	97
August	109
September	98
October	124
November	112
December	

Civil Process

Month Received	Count
January	72
February	63
March	81
April	71
May	35
June	48
July	64
August	99
September	77
October	66
November	67
December	

Prisoner Transports

Month Reported	Count
January	11
February	15
March	15
April	6
May	16
June	10
July	11
August	11
September	10
October	11
November	14
December	

Arrest

Month Arrested	Count
January	19
February	8
March	4
April	12
May	15
June	13
July	9
August	13
September	19
October	17
November	14
December	

Citations

Month Issued	Count
January	17
February	8
March	13
April	71
May	12
June	21
July	6
August	14
September	46
October	8
November	9
December	

Traffic Stops

Month Occurred	Count
January	63
February	31
March	56
April	109
May	53
June	47
July	22
August	38
September	90
October	31
November	30
December	

	Deputy	Year	UNIT#	Total Mileage
Seven full time Law Enforcement Deputies.	Q-1	19	9651	2426
1 Sheriff	Q-2	18	7016	28279
1 Under Sheriff	Q-3	16	7213	42408
5 Deputies	Q-4	15	2323	27000
	Q-5	15	2317	26351
	Q-6	14	6749	102508
	Q-7	10	8905	87085

Russell Shafer, Sheriff

December 31, 2018  
 Quay County Sheriff's Office monthly report.

Calls for Service

Month Reported	Count
January	87
February	76
March	120
April	109
May	116
June	101
July	97
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October	124
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December	113

Civil Process

Month Received	Count
January	72
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July	64
August	99
September	77
October	66
November	67
December	66

Prisoner Transports

Month Reported	Count
January	11
February	15
March	15
April	6
May	16
June	10
July	11
August	11
September	10
October	11
November	14
December	13

Arrest

Month Arrested	Count
January	19
February	8
March	4
April	12
May	15
June	13
July	9
August	13
September	19
October	17
November	14
December	14

Citations

Month Issued	Count
January	17
February	8
March	13
April	71
May	12
June	21
July	6
August	14
September	46
October	8
November	9
December	6

Traffic Stops

Month Occurred	Count
January	63
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	Deputy	Year	UNIT#	Total Mileage
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5 Deputies	Q-4	15	2323	27000
	Q-5	15	2317	26351
	Q-6	14	6749	102508
	Q-7	10	8905	87085



**COPY** EMS FUND ACT

LOCAL FUNDING PROGRAM APPLICATION

FISCAL YEAR 2020

Due Date: January 25, 2019

Submit to:  
 EMS Bureau  
 1301 Siler Rd Bldg F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

**To All Potential Applicants:**

The EMS Fund Act was created for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life.

In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution. **To be eligible**, an applicant must be an incorporated municipality or county applying on behalf of a **local recipient** (publicly owned or contracted ambulance or air ambulance service, medical rescue service, fire department rescue service, regionalized emergency medical service agency; or other prehospital emergency medical service care provider based in state). Your service must also be compliant with NMEMSTARS Data V.3 Elite, and Medical Rescue Certification, if not a PRC Service. **NOTE: You must be transitioning over to V.3 by December 1, 2018 and contacted the EMS Bureau of your transfer.**

Your Application and Annual Report **must be postmarked or hand-delivered** to the EMS Bureau by **5:00pm on Friday, January 25, 2019**. Please adhere to the following instructions, as **incomplete applications will not be processed**:

- Submit an **ORIGINAL AND THREE (3) COPIES – Annual Service Report as well. Failure to make copies will result in an incomplete application and will not be accepted.** (faxed or emailed applications will not be accepted as well)
- **NO SPECIAL BINDING** (one staple in the left top corner only- **NO PAPERCLIPS or BINDERS**)
- Be sure to have necessary **SIGNATURES** and **NOTARY**.

<b>Local Recipient:</b>	Conservancy Fire District #1		032153		
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>	
<b>Mailing Address:</b>	P.O. Box 725		Tucumcari	NM	88401
	<i>(Street/Mailing Address)</i>		<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	1	2 <input checked="" type="checkbox"/>	3	(575) 403-8807	(575) 403-7682
	<i>(EMS Region)</i>		<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
	Michelle Jaynes		Secretary/Treasurer	Michelle.jaynes5@gmail.com	
	<i>(Name)</i>		<i>(Title)</i>	<i>(E-mail Address)</i>	

<b>Applicant:</b>	Quay County - Conservancy Fire District #1				
	<i>(County or Municipality serving as Fiscal Agent)</i>				
<b>Mailing Address:</b>	P.O. Box 1246		Tucumcari	NM	88401
	<i>(Mailing Address)</i>		<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	Cheryl Simpson		Financial Secretary		
	<i>(Name)</i>		<i>(Title)</i>		
	(575) 461-2112	(575) 461-6208	Cheryl.simpson@quaycounty-nm.gov		
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>		

## EMS AGENCY FUNDING INFORMATION

The minimum distribution of funds is based on the following criteria. Assure the agency meets each criterion for the level for which the agency is applying. If each box under a particular level cannot be checked off, the applying service may not be eligible to receive EMS Fund Act funds. Choose **one (1) level** for which your service meets or exceeds the criteria. **(All responses are subject to review and verification).**

Medical-Rescue Service Entry Level (\$1,500)	Medical-Rescue Service First Responder (\$3,000)	Medical-Rescue Service/Ambulance Basic Level (\$5,000)	Medical-Rescue Service/Ambulance Advance Level (\$7,000)
<input type="checkbox"/> <b>Check if applicable</b> Fifty percent (50%) of all runs are covered by a NM licensed First Responder (within two years of the initial request for funding).	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs are covered by a NM licensed First Responder or NM licensed EMT, <u>minimum of two NM licensed personnel.</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, <u>minimum of two NM licensed personnel.</u>	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-I or EMT-P level, <u>minimum of two NM licensed personnel.</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has Basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.
<input type="checkbox"/> <b>Check if applicable</b> The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> <b>Check if applicable</b> Service plans to routinely respond (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations
			<input type="checkbox"/> <b>Check if applicable</b> If applicable, Service complies with Air Ambulance certification regulations 7.27.5 NMAC.

## LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

- Please complete the Equipment Inventory Report prior to listing your funding requests.
- Funds may only be utilized to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical personnel. Please round all estimated costs to the nearest \$100. We must be realistic, please estimate amount closest to funding that service receives every year.
- Use each number only once. (Use additional sheets if necessary.)

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
<b>Repair and Maintenance:</b>		
1	Supplies needed for Rescue and to replace supplies used on runs	\$500.00
4	Pagers replacement	\$2300.00
2	AED Batteries and Pads	\$200.00
<b>Training:</b>		
2	Continue Education for EMT's	\$400.00
<b>Mileage &amp; Per Diem:</b>		
3	Mileage & Per Diem to for EMT's to attend Region III conference.	\$800.00
<b>Supplies (Items Under \$500):</b>		
<b>**Capital Outlay (Items Over \$500):</b>		
<b>Other Operational Costs:</b>		
1	Medical Radio for Rescue Unit	\$800.00
<b>TOTAL AMOUNT OF REQUEST:</b>		\$5000.00

\* Do not make all items Priority No. 1.

\*\* For **Capital Outlay Projects** for which the service intends to "carry over" funds for multiple years in order to pay for a particularly expensive item, the following criteria must be documented and/or met:

- Maximum number of years for single project is 3 - 5 years
- Item and savings plan must be described, including amount designated for item each year
- Carry over request for designated project money must accompany the required end of year fiscal year expenditure report
- Amount of project designated money for the year and carry-over request amount must match
- 

**Note:** If project changes, the designated project money must be returned unless bureau approval for other expenditure is Obtained ( Communication is key here )

## JUSTIFICATION OF TOP PRIORITIES

Please justify your priorities on this application in accordance with the type and level of service you provide and the resources and capabilities of other EMS services in the area. Why are these top priorities? (Use additional sheets if necessary.)

Our department priority is always on training and maintaining the EMS status with the required continuing education for our medics. All our EMT personnel are volunteers so we want to pay for all their training if possible. We will continue the necessary and important upkeep on our MED/Rescue vehicle. We must also replace equipment like the AED batteries and pads. Also pagers and radios are always a major upkeep.

**SERVICE NAME:** Conservancy Fire District #1

**EMS FUND ACT CERTIFICATION BY APPLICANT**

STATE OF NEW MEXICO, COUNTY OF Quay

Pursuant to the Emergency Medical Services Fund Act Program 7.27.4 NMAC, I the undersigned:  
(TYPE OR PRINT)

Franklin McCasland

**Mayor OR Chairman, Board of Commissioners**

Quay

**Municipality County**

I do certify that the information contained in the application is true and correct to the best of my knowledge and information; and that the following specific conditions are satisfactorily met in accordance with the EMS Fund Act Program 7.27.4 NMAC:

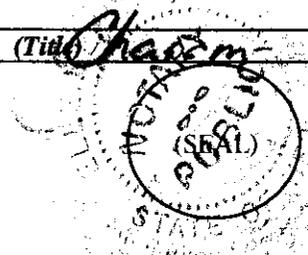
- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
- That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political subdivision.
- That accountability and reporting of these funds shall be in accordance with the requirements set forth by the Local Government Division of the New Mexico Department of Finance and Administration.
- That the funds distributed under the Act will not supplant other funds budgeted and designated for emergency medical service purposes.

*Franklin McCasland*  
Signature of Official Named Above

The above was sworn and subscribed to before this 9 day of January, 2019 (Title) Chairman

Notary Public: Ellen P. White

My commission expires: 3-21-19



**PERSON COMPLETING FORM**

**Name:** John Hinze (Name) Chief (Title)

**Address:** 6291 Quay Road AQ  
Tucumcari (City) NM (State) 88401 (Zip) (+4)

(575) 461-2724 (Work Phone) (575) 461-7682 (Home Phone #) (575) 403-7682 (Cellular Phone #) johnhinze@icloud.com (E-mail Address)

**Signature:** *J. Hinze*

**FOR BUREAU USE ONLY**

Reviewer: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Approved: Yes No Final Award: \_\_\_\_\_

Comments/Problem: \_\_\_\_\_

Date Corrected: \_\_\_\_\_

## Equipment Inventory Report

The following equipment and disposable supplies are required by the Public Regulation Commission and the Medical Rescue Certification regulations. Items that are missing, broken or depleted should be considered as top priority items for funding requests. (Please indicate below the number of items "on hand")

### Front of Vehicle Cab or Optimal Location:

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 - 1lb)	1	Siren	1
Flashlight	2	Spare Tire	1
Fuses (appropriate sizes)	1	Star of Life Displayed	1
Jack and Handle	1	Tool Box	1
Lug Wrench	1	Triage Tags for MCI's	1
Maps or Navigational equipment	1	U.S. DOT Emergency Response Guidebook	1
Patient Care Reports or Reporting System	1	Vehicle Registration	1
Roadway warning devices	1	Vehicle Spotlight or auxiliary lighting	1
Service Specific Protocols and guidelines	1	Warning Lights	1
Other: <i>(Specify)</i>			

### Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	10	Spare Batteries/charger system	2
EMSCOM (UHF) Radio	0		
Other: <i>(Specify)</i>			

### Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	1000	Helmet with Face Shield	10
Eye Protection	10	N-95 mask (or > particulate mask)	10
Gloves (Leather or heavy duty)	10	Safety Vest/Jacket/(ANSI 2008 Compliant)	10
Hearing Protection	10	Splash Protection (disposable)	2
Other: <i>(Specify)</i>			

## Diagnostic Equipment

Item Description	On Hand	Item Description	On Hand
Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs	4		
Entitled CO2 monitoring device (optional)	1	Pulse Oximeter	1
Glucose Monitoring Instrument	2	Stethoscope	4
Penlights	10	Thermometer (Patient)	2
Other: (Specify)			

## Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	4	Oxygen Delivery Devices (Adult, Child and Infant Sizes)	0
Auto Ventilator Devices (ATV/MTV)	0	Oxygen Supply Tubing	0
Bag Valve Mask Devices (Adult, Child and Infant)	2	Patient Restraints	4
Band-Aids (Assorted Sizes)	400	Pediatric Drug Dosage Tape or chart	2
Biohazard Clean-up Supplies	10	Pediatric Restraint device/car seat	1
Biohazard Waste bags	100	Pillows	2
Blankets	2	Portable Oxygen Equipment	0
Body Bags	0	Portable Suction Unit	0
Cervical Collars - Rigid (Adult, Child and Infant)	10	Seated Spinal Immobilization Device	1
Cervical Immobilization Devices	1	Semi-Automatic Defibrillator with Pads	1
Chair Stretcher	0	Semi-Automatic Defibrillator Batteries	1
Cold Pack	10	Sharps Container	1
Cold Weather Warming Devices	4	Sheets	0
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	40	Shoulder/chest/extremity straps	2
Emesis Basin	4	Spinal Immobilization device/backboard	4
Field Stretcher (Scoop, Collapsible, Vacuum)	1	Splints, Extremity (Rigid, Air, Vacuum)	4
Foil Blanket	4	Sterile Burn Sheets	2
Hand Sanitizer	10	Sterile Gloves (Assorted Sizes)	200
Heat Pack	5	Sterile Water	5
Inhalation Therapy Equipment	0	Stokes Basket	1
Installed Oxygen System	0	Suction Catheters (Soft & Rigid)	0
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	700	Supraglottic Airway Devices	0
Long Backboard	4	Multi-lumen Airway Devices	0
Multi-level Stretcher	0	Laryngeal Airway Devices	10
Multi-Lumen Airways	0	Towels	0
Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2	Traction Splint	1
Nasopharyngeal Airways	10	Trauma Dressings	10
Occlusive Dressings	10	Trauma Shears	10
On-Board Suction System	0	Triangular Bandages	20
On-Board Oxygen Supply	0	Urinal (Male and Female)	1
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	4		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for First Responder, EMT-Basic and the Service Medical Director			(Circle) Yes No

Other: (Specify)			
<b>Advance Level</b>			
Alcohol and Betadine Prep Pads	0	IV Fluid (Normal Saline, D5W, LR)	0
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)	0	Laryngoscope Blades – Adult	0
Chest Decompression Catheters	0	Laryngoscope Blades –Peds	0
Cricothyroidotomy Kit	0	Laryngoscope Handle	0
EKG Monitor Electrodes	0	Magill Forceps	0
Electrode Defib Pads	0	Needles (Assorted Gauges)	0
		Pediatric Fluid Control Device	0
Endotracheal Tubes (Assorted)	0	Scalpels	
Ext. Cardiac Pacing Pads	0	Syringes (1cc, 3cc, 5cc, 10cc)	0
Infusion Pumps	0	Toomey Syringe (60cc)	0
Inhalation Therapy Equipment	0	Tubes, Blood Drawing (Assorted Sizes and Types)	0
Intraosseous Needles	0	Tubing, IV Administration (60gts)	0
IV Catheters	0	Tubing, IV Administration Set (10gts – 20gts)	0
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Intermediate and EMT- Paramedic, and the Service Medical Director			(Circle) Yes No
Other: (Specify)			



Submit to:  
 EMS Bureau  
 1301 Siler Rd Bldg. F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

<b>Service Name:</b>	Conservancy Fire District #1 Quay County <i>(EMS Service)</i>
----------------------	--

<b>Mailing Address:</b>	P.O. Box 725			
	<i>(Mailing Address)</i>			
	Tucumcari	NM	88401	0725
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>Contact Person:</b>	Michelle Jaynes		Secretary/Treasurer	
	<i>(Name)</i>		<i>(Title)</i>	
	(575) 461-2351	(575) 815-9015	(575) 461-4061	Michelle.jaynes5@gmail.com
	<i>(Business Phone)</i>	<i>(Emergency Phone)</i>	<i>(Fax)</i>	<i>(E-mail Address)</i>
<b>Administration:</b>	Quay County			
	<i>(County or Municipality)</i>			
	P.O. Box 1246			
	<i>(Mailing Address)</i>			
<b>Contact Person:</b>	Richard Primrose		Quay County Manager	
	<i>(Name)</i>		<i>(Title)</i>	
	(575) 461-2112	(575) 461-6208	Richard.primrose@quaycounty-nm.gov	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	
<b>EMS Region:</b>	<b>Region I</b>	<b>Region II</b>	<b>Region III</b>	<input checked="" type="checkbox"/>

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Conservancy Fire District #1 Main Station			
	35.16090 North	103.7474 West		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	1002 Camino del Coronado			
	Tucumcari	NM	88401	0725
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>	Conservancy Fire District #1 Sub Station			
	35.2229 North	103.7735 West		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	6649 Quay Road AR			
	Tucumcari	NM	88401	0725
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<i>(Use additional pages as necessary)</i>				

<b>Service Name:</b>	Conservancy Fire District #1 Quay County
	<i>(EMS Service)</i>

SERVICE INFORMATION			
Type of Service (Must Check Only One)		Affiliation Type (Mark Primary Affiliation Only)	
<input type="checkbox"/>	Certified PRC Ambulance	Private for-profit with a County or Municipality Contract	
<input checked="" type="checkbox"/>	Certified Medical/Rescue Service (Non-transport)	Private non-profit with a County or Municipality Contract	
<input type="checkbox"/>	Certified Medical/Rescue Service (Transport Capable)	Fire Dept.-based	
<input type="checkbox"/>	Emergency Medical Dispatch Agency	Law Enforcement or Department of Public Safety-based	
<input type="checkbox"/>	Special Event(s) Agency	Clinic-based	
<input type="checkbox"/>	Air Ambulance with a County or Municipality Contract	Hospital-based	
<input type="checkbox"/>	Other (Please Specify):	<input checked="" type="checkbox"/>	County-based
			Municipality-based
			Tribal
			Other (Please Specify):
<b>PRC Certification #</b>			
<b>Medical Rescue Certification #</b>			
<b># of Years in Operation</b>			
<b>EMS Calls</b>		<b>Local Receiving Hospital(s)</b>	
<b>Received By (Mark One)</b>	<b>Dispatched by (Mark One)</b>		
<input type="checkbox"/> Basic 911	<input type="checkbox"/> Ambulance Service	<input checked="" type="checkbox"/> Central Dispatch	
<input checked="" type="checkbox"/> Enhanced 911	<input type="checkbox"/> Fire Department	Location of Dispatch:	
<input type="checkbox"/> Local Phone	<input type="checkbox"/> Law Enforcement		

EMERGENCY MEDICAL SERVICES PERSONNEL					
LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL					
	Paid (Indicate Part Time/Full Time)		Volunteer*		
EMS First Responder	0	0		Emergency Medical Dispatch Instructor	0
EMT Basic	0	2		Nurse	0
EMT Intermediate	0	1		Physician	0
EMT Paramedic	0	0		Driver	0
Emergency Medical Dispatcher	0	0		Other	0

\*Volunteer may include those paid by the run or other non-salary arrangement.

LICENSED EMS PERSONNEL					
List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. <i>(Use additional pages as necessary.)</i>					
Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Scot Jaynes	EMT-B	09000746	3/31/2020	12/01/2017	Volunteer
Michelle Jaynes	EMT-B	09000741	3/31/2020	12/01/2017	Volunteer
Esteban Garcia	EMT-I	16000417	3/31/2020	12/01/2017	Volunteer



<b>Service Name:</b>	Conservancy Fire District #1 Quay County
	<i>(EMS Service)</i>

**For Ground Ambulance/Medical Rescue Services Only**

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)**

List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)

Name	Driver's License Number and State	EVOC Course Date	Class of NMDL	Other Medical Training
John E. Hinze	NM 014845615	Sept. 2017	E	Former EMT-B
Lucas Henry Bugg	NM501149195	Sept. 2017	E	
Todd Harding Smith	NM053430503	Sept. 2017	E	

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLES**

Enter the total number of each type of vehicle used by your service. *(Mandatory)*

Type I:		Type IV:	
Type II:		Medical/Rescue:	1 Non Transport
Type III:		Other - Explain:	

List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four-wheel drive, patient capacity for supine patients, and the current mileage. *(Mandatory)*

*(Use additional pages as necessary)*

Year	Make And Model	Type of Vehicle	License Number	State Assigned EMSCOM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
2015	Dodge Ram 5500	Type 5	G90968		2-15	4WD	0	3746.0	August 2018
2005	Ford F-150	Type 6	G64360		7-05	4WD	0	87824.9	
2004	Freightliner	Class A	G65379		12-04	2WD	0	17751.8	
2016	Dodge Ram 5500	Type 5	G98169		5-16	4WD	0	2807.3	
2004	Dodge Ram 3500	Type 6	G98122		8-04	4WD	0	152802.1	
2010	Freightliner	Class A	G82655		10-10	2WD	0	5137.9	
1986	Military 6X6	Type 4	G89189		4-86	4WD	0	13493.7	
1986	Ford	Engine	G13810		6-86	2WD	0		
1999	Chevy 1 ton	Type 6	G65977		3-99	4WD	0		

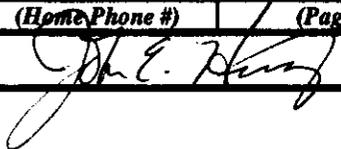
*(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)*

<b>Service Name:</b>	Conservancy Fire District #1 Quay County
	<i>(EMS Service)</i>

VEHICLE PREVENTIVE MAINTENANCE PROGRAM					
1. Do you have a Vehicle Preventive Maintenance Program in place?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", please attach a copy of your program.					
2. Indicate the frequency of vehicle inspections:		<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly
3. Attach Annual Safety Inspection for all units. (PRC ONLY)					

OPERATIONS PLAN			
Please provide information on the Operations Plan for your service.			
1. Do you have an Operations Plan?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Are operational and medical protocols included in the Operations Plan?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. What was the effective date of your Operations Plan?		12/31/2007	
4. Please provide a map of the coverage area for your service.			

QUALITY ASSURANCE REVIEW						
1. Do you have an internal quality assurance/improvement mechanism in place?				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", please attach a brief description.						
2. Indicate the dates of this year's quality assurance review activities.						
Reviews are conducted:		<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Annually
DATES OF REVIEW						
DATE	DATE	DATE	DATE	DATE		
12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015		
12/31/16	12/31/17	12/01/2018				

SERVICE DIRECTOR/CHIEF				
<b>Name:</b>	John Hinze		Chief	
	<i>(Name)</i>		<i>(Title)</i>	
<b>Address:</b>	P.O. Box 725		Tucumcari	NM 88401
	<i>(Street/Mailing)</i>		<i>(City)</i>	<i>(State)</i> <span style="float: right;"><i>(Zip)</i></span>
(575) 461-2724	(575) 461-8691		(575) 403-7682	pastorjohn@fbctuc.com
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				

<b>Service Name:</b>	Conservancy Fire District #1 Quay County (EMS Service)
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SERVICE MEDICAL DIRECTOR				
<b>Name:</b>	Dr. George Evetts (Name)	Medical Director (Title)	60-36NM (License #)	
<b>Address:</b>	P.O. Box 1128 (Street/Mailing)	Tucumcari (City)	NM (State)	88401 (Zip)
(Work Phone)	(575) 461-4765 (Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<i>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</i>				
<b>*Signature:</b>	<i>George Evetts M.D.</i>			

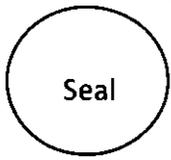
SERVICE TRAINING COORDINATOR				
<b>Name:</b>	Michelle Jaynes (Name)	Sec/Bookkeeper (Title)	09000741 (License #)	EMT-B (Level)
<b>Address:</b>	P.O. Box 725 (Street/Mailing)	Tucumcari (City)	NM (State)	88401 (Zip)
(Work Phone)	(575) 461-2351 (Home Phone #)	(Pager #)	(575) 815-9015 (Cellular Phone #)	Michelle.jaynes5@gmail.com (E-mail Address)
<b>Signature:</b>	<i>Michelle D. Jaynes</i>			

PERSON COMPLETING FORM				
<b>Name:</b>	John Hinze (Name)	Chief (Title)		
<b>Address:</b>	P.O. Box 725 (Street/Mailing)	Tucumcari (City)	NM (State)	88401 (Zip)
(Work Phone)	(575) 461-2724 (Home Phone #)	(Pager #)	(575) 403-7682 (Cellular Phone #)	johnhinze@icloud.com (E-mail Address)
<b>Signature:</b>	<i>John Hinze</i>			

The above was sworn and subscribed to before this 2nd Day of January, 2019

*Sheryl Chambers*  
Notary Public

08/19/2019  
My Commission Expires



\*\*\*\* Notary is for the person completing form



**EMS ANNUAL SERVICE REPORT**  
**Fiscal Year 2020**  
 Due Date: January 25, 2019

Submit to:  
 EMS Bureau  
 1301 Siler Rd Bldg. F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

<b>Service Name:</b>	QUAY FIRE DEPARTMENT <i>(EMS Service)</i>
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<b>Mailing Address:</b>	PO Box 643 <i>(Mailing Address)</i>			
	Tucumcari <i>(City)</i>	NM <i>(State)</i>	88401 <i>(Zip)</i>	0643 <i>(+4)</i>
	Paula O'Steen <i>(Name)</i>			
	EMS Director <i>(Title)</i>			
<b>Contact Person:</b>	(575) 487-2002 <i>(Business Phone)</i>	(575) 760-7961 <i>(Emergency Phone)</i>		osteenp2000@yahoo.com <i>(E-mail Address)</i>
	Quay County <i>(County or Municipality)</i>			
	PO Box 1246 <i>(Mailing Address)</i>			
<b>Administration:</b>	Tucumcari <i>(City)</i>	NM <i>(State)</i>	88401 <i>(Zip)</i>	1246 <i>(+4)</i>
	Richard Primrose <i>(Name)</i>			
	County Manager <i>(Title)</i>			
	(575) 461-2112 <i>(Telephone #)</i>	(575) 461-6208 <i>(Fax Phone #)</i>	richard.primrose@quaycounty-nm.gov <i>(E-mail Address)</i>	
<b>EMS Region:</b>	Region I	Region II	Region III	X

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Quay Fire Department			
	N34°55.448 <i>Latitude</i>		W103°45.710 <i>Longitude</i>	
<b>Street Address:</b>	4209 Quay Road 46			
	Tucumcari <i>(City)</i>	NM <i>(State)</i>	88401 <i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>				
	<i>Latitude</i>		<i>Longitude</i>	
<b>Street Address:</b>				
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<i>(Use additional pages as necessary)</i>				

<b>Service Name:</b>	<b>QUAY FIRE DEPARTMENT</b> <i>(EMS Service)</i>
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SERVICE INFORMATION			
Type of Service <i>(Must Check Only One)</i>		Affiliation Type <i>(Mark Primary Affiliation Only)</i>	
<input type="checkbox"/>	Certified PRC Ambulance	<input type="checkbox"/>	Private for-profit with a County or Municipality Contract
<input type="checkbox"/>	Certified Medical/Rescue Service (Non-transport)	<input type="checkbox"/>	Private non-profit with a County or Municipality Contract
<input checked="" type="checkbox"/>	Certified Medical/Rescue Service (Transport Capable)	<input checked="" type="checkbox"/>	Fire Dept.-based
<input type="checkbox"/>	Emergency Medical Dispatch Agency	<input type="checkbox"/>	Law Enforcement or Department of Public Safety-based
<input type="checkbox"/>	Special Event(s) Agency	<input type="checkbox"/>	Clinic-based
<input type="checkbox"/>	Air Ambulance with a County or Municipality Contract	<input type="checkbox"/>	Hospital-based
<input type="checkbox"/>	Other (Please Specify):	<input type="checkbox"/>	County-based
<input type="checkbox"/>		<input type="checkbox"/>	Municipality-based
<input type="checkbox"/>		<input type="checkbox"/>	Tribal
<b>PRC Certification #</b>		<b>Other (Please Specify):</b>	
<b>Medical Rescue Certification #</b>	321359		
<b># of Years in Operation</b>	29		
EMS Calls		Local Receiving Hospital(s)	
<b>Received By <i>(Mark One)</i></b>	<b>Dispatched by <i>(Mark One)</i></b>	Dan C Trigg Hospital	
<input type="checkbox"/>	Basic 911	<input type="checkbox"/>	Ambulance Service
<input checked="" type="checkbox"/>	Enhanced 911	<input checked="" type="checkbox"/>	Central Dispatch
<input type="checkbox"/>	Local Phone	<input type="checkbox"/>	Fire Department
		<input type="checkbox"/>	Law Enforcement
			Location of Dispatch:

EMERGENCY MEDICAL SERVICES PERSONNEL					
LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL					
	Paid (Indicate Part Time/Full Time)	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder		1	Emergency Medical Dispatch Instructor		
EMT Basic			Nurse		
EMT Intermediate		2	Physician		
EMT Paramedic		1	Driver		
Emergency Medical Dispatcher			Other		

\*Volunteer may include those paid by the run or other non-salary arrangement.

LICENSED EMS PERSONNEL					
List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. <i>(Use additional pages as necessary.)</i>					
Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Hampton, Teresa	FR	00020895	03/31/2019	12/09/2018	Volunteer
Nunez, Jennifer	EMT-I	00020467	03/31/2020	12/09/2018	Volunteer
O'Steen, Paula	EMT-I	00012649	03/31/2020	12/09/2018	Volunteer
Blair, Eric	EMT-P	02000150	03/31/2019	12/09/2018	Volunteer



Service Name:	QUAY FIRE DEPARTMENT
	(EMS Service)

**For Ground Ambulance/Medical Rescue Services Only**

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)**

List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)

Name	Driver's License Number and State	EVOC Course Date	Class of NMDL	Other Medical Training

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLES**

Enter the total number of each type of vehicle used by your service. (Mandatory)

Type I:		Type IV:	
Type II:	1	Medical/Rescue:	1 -
Type III:		Other - Explain:	

List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four-wheel drive, patient capacity for supine patients, and the current mileage. (Mandatory)  
(Use additional pages as necessary)

Year	Make And Model	Type of Vehicle	License Number	State Assigned EMSCOM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
2002	E-350	Type 1	G-82317	2794	2002	2	2	204,662	09/10/2018
2003	Freightliner	Class A	G-57657		2003	4	0	42,807	
2010	Freightliner	QA	G-79866		2010	4	0	3,592.6	
1996	Dodge	Brush	G-31070		1996	4	0	5,831	
2004	Chevy	Brush	G-88484		2004	4	0	168,956	
2016	Dodge	Brush	G-98172		2016	4	0	2,053	
2016	Freightliner	Tender	G-98171		2016	4	0	2,279.4	

(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)

Service Name:	QUAY FIRE DEPARTMENT
	(EMS Service)

VEHICLE PREVENTIVE MAINTENANCE PROGRAM				
1. Do you have a Vehicle Preventive Maintenance Program in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a copy of your program.				
2. Indicate the frequency of vehicle inspections:	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly
	<input type="checkbox"/>	Monthly	<input checked="" type="checkbox"/>	Quarterly
3. Attach Annual Safety Inspection for all units. (PRC ONLY)				

OPERATIONS PLAN			
Please provide information on the Operations Plan for your service.			
1. Do you have an Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>
2. Are operational and medical protocols included in the Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>
3. What was the effective date of your Operations Plan?	January 2017		
4. Please provide a map of the coverage area for your service.			

QUALITY ASSURANCE REVIEW				
1. Do you have an internal quality assurance/improvement mechanism in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a brief description.				
2. Indicate the dates of this year's quality assurance review activities.				
Reviews are conducted:	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly
	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
	<input checked="" type="checkbox"/>	Annually		
DATES OF REVIEW				
DATE	DATE	DATE	DATE	DATE
12/31/2018				

SERVICE DIRECTOR/CHIEF				
Name:	Gerald Hight		Chief	
	(Name)		(Title)	
Address:	4314 Quay Road 50.4		Tucumcari	NM 88401
	(Street/Mailing)		(City)	(State) (Zip)
(575) 487-2002	(575) 487-9514			ghight@plateautel.net
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
Signature:	<i>Gerald Hight</i>			

Service Name:	QUAY FIRE DEPARTMENT
	(EMS Service)

SERVICE MEDICAL DIRECTOR				
Name:	George E Evetts	Medical Director	60-36 NM	
	(Name)	(Title)	(License #)	
Address:	PO Box 1128	Tucumcari	NM	88401
	(Street/Mailing)	(City)	(State)	(Zip)
(Work Phone)	(575) 461-0591	(Pager #)	(Cellular Phone #)	gevetts@sr66.com
	(Home Phone #)			(E-mail Address)
<i>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</i>				
*Signature:	<i>George E Evetts MD</i>			

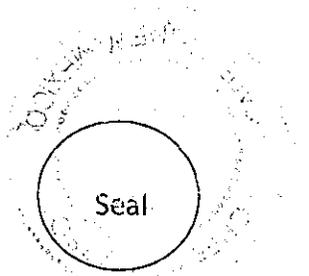
SERVICE TRAINING COORDINATOR				
Name:	Paula O'Steen	EMS Director	00012649	EMT-I
	(Name)	(Title)	(License #)	(Level)
Address:	PO Box 643	Tucumcari	NM	88401
	(Street/Mailing)	(City)	(State)	(Zip)
(575) 487-2002	(575) 403-7961	(575) 760-7961	osteenp2000@yahoo.com	
(Work Phone)	(Home Phone #)	(Cellular Phone #)	(E-mail Address)	
Signature:	<i>Paula O'Steen</i>			

PERSON COMPLETING FORM				
Name:	Paula O'Steen	EMS Director		
	(Name)	(Title)		
Address:	PO Box 643	Tucumcari	NM	88401
	(Street/Mailing)	(City)	(State)	(Zip)
(575) 487-2002	(575) 403-7961	(575) 760-7961	osteenp2000@yahoo.com	
(Work Phone)	(Home Phone #)	(Cellular Phone #)	(E-mail Address)	
Signature:	<i>Paula O'Steen</i>			

The above was sworn and subscribed to before this 17<sup>th</sup> Day of December, 2018

*Cheryl Simpson*  
Notary Public

8/25/2019  
My Commission Expires



\*\*\*\* Notary is for the person completing form

MR46 - 2002 Medical Rescue  
 Vin #1FDXE45F52H

QUAY FIRE DEPARTMENT  
 VEHICLE CHECK LIST

License Plate G-82317  
 Patient Capacity - 2

DATE: January , 2019

ITEM CHECKED	ITEM CHECKED
Mileage	Unit Washed
Tire Condition	Parking Brake
Tire Pressure	Horn
Spare Tire	Windshield Wipers
Headlights, High	Clean All Glass
Turn Signals	Fire Extinguishers
Tail Lights	Engine Oil
Brake Lights	Brake Fluid
Back-up Alarm	Radiator Fluid
Siren / PA	Washer Fluid
Light Bar	Battery Terminals
Rear Warning Lights	Battery Water
Flood Lights	Engine Belts
Rear Work Lights	Engine Hoses
Radio Check	Power Steering Fluid
Run Reports	Heater / A/C
Hazard Flasher	Spotlight
Throttle	Dome Light
Seat Belts Operational	Tools

DATE: February , 2019

ITEM CHECKED	ITEM CHECKED
Mileage	Unit Washed
Tire Condition	Parking Brake
Tire Pressure	Horn
Spare Tire	Windshield Wipers
Headlights, High	Clean All Glass
Turn Signals	Fire Extinguishers
Tail Lights	Engine Oil
Brake Lights	Brake Fluid
Back-up Alarm	Radiator Fluid
Siren / PA	Washer Fluid
Light Bar	Battery Terminals
Rear Warning Lights	Battery Water
Flood Lights	Engine Belts
Rear Work Lights	Engine Hoses
Radio Check	Power Steering Fluid
Run Reports	Heater / A/C
Hazard Flasher	Spotlight
Throttle	Dome Light
Seat Belts Operational	Tools

UNITS CHECKED BY: \_\_\_\_\_

On Board O2

Portable O2

# RECORD OF ANNUAL INSPECTION

(49 CFR, 396. 17-23)

DATE

9-10-2018

Prepare Separate Report for Each Vehicle Inspected

02872409

COMPANY NAME <b>Quay Fire Dept #4</b>		VEHICLE TYPE <input checked="" type="checkbox"/> TRUCK <input type="checkbox"/> TRACTOR <input type="checkbox"/> TRAILER <input type="checkbox"/> CONVERTER <input type="checkbox"/> DOLLY <b>Rescue Unit</b>	
STREET ADDRESS <b>PO Box 643</b>		VEHICLE MAKE MODEL YEAR <b>Ford E350 2002</b>	
CITY STATE ZIP <b>Tucuman NM 88401</b>	VEHICLE IDENTIFICATION (Company No., State Tag No. or VIN) <b>1FXE45FB2HR00146</b>		
INSPECTOR'S NAME (Please Print) <b>Craig Brashear</b>		EMPLOYEE NO. <b>1201</b>	

## REPORT OF CONDITION (For Detailed Information on Inspection Procedures see FMCSR Section 396, Appendix G)

	OK	REPAIR		OK	REPAIR		OK	REPAIR		OK	REPAIR
<b>BRAKES</b>			<b>EXHAUST</b>			<b>STEERING</b>			<b>FRAME</b>		
Adjustment	✓		Leaks	✓		Adjustment	✓		Members	✓	
Mechan. Compon.	✓		Placement	✓		Column/Gear	✓		Clearance	✓	
Drum/Rotor	✓		<b>LIGHTING</b>			Axle	✓				
Hose/Tubing	✓		Headlights	✓		Linkage	✓		<b>TIRES</b>		
Lining	✓		Tail/Stop	✓		Power Steering	✓		Tread	✓	
Low Air Warning	N/A		Clearance/Marker	✓		Other			Inflation	✓	
Trailer Air Supply	N/A		Identification	✓		<b>FUEL SYSTEM</b>			Damage		
Compressor	N/A		Reflectors	✓		Tank(s)	✓		Other		
Parking Brakes	✓		Other			Lines	✓				
Other									<b>WHEELS/RIM</b>		
			<b>CAB/BODY</b>			<b>SUSPENSION</b>			Fasteners	✓	
<b>COUPLERS</b>			Access	✓		Springs	✓		Disc/Spoke		
Fifth-Wheel & Mount	N/A		Eqpt./Load Secure	✓		Attachments	✓				
Pin/Upper Plate	✓		Tie-Downs	N/A		Sliders	N/A		<b>WINDSHIELD</b>	✓	
Pintle-Hook/Eye	✓		Headerboard	N/A						✓	
Safety Chain(s)	✓		Other			<b>MIRRORS</b>	✓		<b>WINDSHLD. WIP.</b>	✓	
							✓			✓	

### REMARKS

Certification: This vehicle has passed all the inspection items for the annual vehicle inspection in accordance with 49 CFR Part 396.

QUALIFIED INSPECTOR'S SIGNATURE

*Craig Brashear*

DATE

9-10-2018

APPLY LABEL TO A CLEAN, DRY SURFACE. USE WITH AN OVERLAMINATE (2402) TO IMPROVE DURABILITY UNDER NORMAL WEATHER CONDITIONS.

AN INDELIBLE INK MARKER IS RECOMMENDED FOR USE WHEN FILLING OUT THE LABEL. INDELIBLE INK IS PERMANENT AND WILL NOT WASH OFF, BUT MAY FADE DUE TO EXPOSURE TO ULTRAVIOLET LIGHT OVER TIME. CAREFUL DISCRETION IS ADVISED REGARDING APPLICATION OF LABEL TO AN AREA NOT EXPOSED TO EXCESSIVE ULTRAVIOLET LIGHT AND/OR ELEMENTS AND IT IS RECOMMENDED THAT THE READABILITY OF THE LABEL BE CHECKED PERIODICALLY.

# QUAY FIRE DEPARTMENT

## OPERATION / PROCEDURES

All EMS run reports will be reviewed annually. All personnel will be present at the time of review.

### VEHICLE INSPECTION

- Use vehicle inspection list to check the working order of each truck
  - Report any problems
- Clean and Wash Truck

### TRUCK SUPPLIES, DRUGS AND EQUIPMENT

- Restock truck after every run
- Intermediates – check off controlled drugs in lock box on truck
- Make sure bag is put back together after every call
- Clean up equipment after every call
- Make sure trucks have run reports with all forms included

### RUN REPORTS

- Fill out reports in a timely manner
- Enter all reports into data base as soon as possible (within 24 hours of run)
- List ALL SUPPLIES used
- Log all reports on log sheet and use log run number on all reports and forms
- Log mileage on all reports (To and From Scene )

- Attach all forms and incident reports if necessary – report any incidents as soon as possible
- Hospital copies must be returned to hospital within 48 hours

Run reports must contain the following, along with the usual information.

- Complete list of all supplies used
- Completed drug use record

Restock truck after each run to assure you have supplies for the next run.

## QUALITY ASSURANCE

1. All EMS responses will have a corresponding NM EMS Service Report or the equivalent completed as soon as possible after the incident. A designated member or committee and/or the system Medical Director must review these reports at least once a month. The purpose of the review is to ensure that appropriate medical care is being provided.
2. Standards that will be evaluated during QA activities are:
  - a. Appropriate medical assessments.
  - b. Compliance with service protocol.
  - c. Appropriate medical control.
  - d. Treatment in compliance with the New Mexico EMS Scope of Practice.
3. A written report of the problem and corrective action will be provided to the service Medical Director.
4. The Medical Director and/or a designee will address problems and discuss any necessary training and counseling.
5. A written report of any disciplinary action and suggested solutions will be provided to personnel involved with the run, if applicable.





**EMS FUND ACT  
LOCAL FUNDING PROGRAM  
APPLICATION  
FISCAL YEAR 2020**

Submit to:  
EMS Bureau  
1301 Siler Rd Bldg F  
Santa Fe, NM 87507  
Attn: Ann Martinez  
505-476-8233

**Due Date: January 25, 2019**

**To All Potential Applicants:**

The EMS Fund Act was created for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life.

In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution. **To be eligible**, an applicant must be an incorporated municipality or county applying on behalf of a **local recipient** (publicly owned or contracted ambulance or air ambulance service, medical rescue service, fire department rescue service, regionalized emergency medical service agency; or other prehospital emergency medical service care provider based in state). Your service must also be compliant with NMEMSTARS Data V.3 Elite, and Medical Rescue Certification, if not a PRC Service. **NOTE: You must be transitioning over to V.3 by December 1, 2018 and contacted the EMS Bureau of your transfer.**

Your Application and Annual Report **must be postmarked or hand-delivered** to the EMS Bureau by **5:00pm on Friday, January 25, 2019**. Please adhere to the following instructions, **as incomplete applications will not be processed:**

- Submit an **ORIGINAL AND THREE (3) COPIES – Annual Service Report as well. Failure to make copies will result in an incomplete application and will not be accepted.** (faxed or emailed applications will not be accepted as well)
- **NO SPECIAL BINDING** (*one staple in the left top corner only- NO PAPERCLIPS or BINDERS*)
- Be sure to have necessary **SIGNATURES** and **NOTARY**.

<b>Local Recipient:</b>	QUAY FIRE DEPARTMENT <i>(EMS Service that will benefit)</i>			0321359 <i>(EMS Service #)</i>	
<b>Mailing Address:</b>	PO Box 643 <i>(Street/Mailing Address)</i>		Tucumcari <i>(City)</i>		NM 88401 <i>(State) (Zip)</i>
	1	2 X	3	(575) 487-2002 <i>(Business Phone #)</i>	(575) 760-7961 <i>(Emergency Phone #)</i>
<b>Contact Person:</b>	Paula O'Steen <i>(Name)</i>		EMS Director <i>(Title)</i>		oseenp2000@yahoo.com <i>(E-mail Address)</i>

<b>Applicant:</b>	QUAY COUNTY <i>(County or Municipality serving as Fiscal Agent)</i>				
<b>Mailing Address:</b>	PO Box 1246 <i>(Mailing Address)</i>		Tucumcari <i>(City)</i>		NM 88401 <i>(State) (Zip)</i>
	Richard Primrose <i>(Name)</i>		County Manager <i>(Title)</i>		
<b>Contact Person:</b>	(575) 461-2112 <i>(Telephone #)</i>		(575) 461-6208 <i>(Fax Phone #)</i>		richard.primrose@quaycounty-nm.gov <i>(E-mail Address)</i>

## EMS AGENCY FUNDING INFORMATION

The minimum distribution of funds is based on the following criteria. Assure the agency meets each criterion for the level for which the agency is applying. If each box under a particular level cannot be checked off, the applying service may not be eligible to receive EMS Fund Act funds. Choose **one (1) level** for which your service meets or exceeds the criteria.

**(All responses are subject to review and verification).**

Medical-Rescue Service Entry Level  ( <b>\$1,500</b> )	Medical-Rescue Service First Responder  ( <b>\$3,000</b> )	Medical-Rescue Service/Ambulance Basic Level  ( <b>\$5,000</b> )	Medical-Rescue Service/Ambulance Advance Level  ( <b>\$7,000</b> )
<input type="checkbox"/> <b>Check if applicable</b> Fifty percent (50%) of all runs are covered by a NM licensed First Responder (within two years of the initial request for funding).	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs are covered by a NM licensed First Responder or NM licensed EMT, <u>minimum of two NM licensed personnel.</u>	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, <u>minimum of two NM licensed personnel.</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-I or EMT-P level, <u>minimum of two NM licensed personnel.</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has Basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.
<input type="checkbox"/> <b>Check if applicable</b> The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> <b>Check if applicable</b> Service plans to routinely respond ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when dispatched for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when dispatched for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS medical protocols.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations
			<input type="checkbox"/> <b>Check if applicable</b> If applicable, Service complies with Air Ambulance certification regulations 7.27.5 NMAC.

## LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

- Please complete the Equipment Inventory Report prior to listing your funding requests.
- Funds may only be utilized to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical personnel. Please round all estimated costs to the nearest \$100. We must be realistic, please estimate amount closest to funding that service receives every year.
- Use each number only once. (Use additional sheets if necessary.)

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
<b>Repair and Maintenance:</b>		
2	Vehicle maintenance / Repairs / Yearly Inspection	\$ 500.00
<b>Training:</b>		
3	Conferences Registrations / Continuing Education / Training / License Renewals	\$1,500.00
	Video Loan	
<b>Mileage &amp; Per Diem:</b>		
4	Per Diem / Mileage for Volunteers to travel for trainings and conferences	\$2,500.00
<b>Supplies (Items Under \$500):</b>		
1	Medical / Non-Medical Supplies / Pharmacy License Renewals / Upgrade	\$2,500.00
	Equipment / Replace Expired Supplies / Medical Rescue Registration	
<b>**Capital Outlay (Items Over \$500):</b>		
<b>Other Operational Costs:</b>		
<b>TOTAL AMOUNT OF REQUEST:</b>		<b>\$7,000.00</b>

\* Do not make all items Priority No. 1.

\*\* For Capital Outlay Projects for which the service intends to "carry over" funds for multiple years in order to pay for a particularly expensive item, the following criteria must be documented and/or met:

- Maximum number of years for single project is 3 - 5 years
- Item and savings plan must be described, including amount designated for item each year
- Carry over request for designated project money must accompany the required end of year fiscal year expenditure report
- Amount of project designated money for the year and carry-over request amount must match
- 

**Note:** If project changes, the designated project money must be returned unless bureau approval for other expenditure is Obtained ( Communication is key here )

## JUSTIFICATION OF TOP PRIORITIES

Please justify your priorities on this application in accordance with the type and level of service you provide and the resources and capabilities of other EMS services in the area. Why are these top priorities? (Use additional sheets if necessary.)

1) Pharmacy Licenses to include clinical and controlled substance licenses renew yearly – you must have these licenses to carry, purchase, and administer medications. Replace expired and used medical supplies. Annual registration of medical rescue unit per New Mexico EMS Bureau / Regulations requirements.

2) Repair / Maintenance of vehicle as needed and annual inspection as required by New Mexico EMS Bureau.

3) Refreshers / Continuing Education for Volunteers to maintain licensure.

4) Per Diem to help volunteers with travel expenses for continuing education, training, and conferences.

SERVICE NAME: QUAY FIRE DEPARTMENT

EMS FUND ACT CERTIFICATION BY APPLICANT

STATE OF NEW MEXICO, COUNTY OF QUAY

Pursuant to the Emergency Medical Services Fund Act Program 7.27.4 NMAC, I the undersigned: (TYPE OR PRINT)

Mayor Franklin McCasland, Chair OR Chairman, Board of Commissioners

QUAY COUNTY

Municipality County

I do certify that the information contained in the application is true and correct to the best of my knowledge and information; and that the following specific conditions are satisfactorily met in accordance with the EMS Fund Act Program 7.27.4 NMAC:

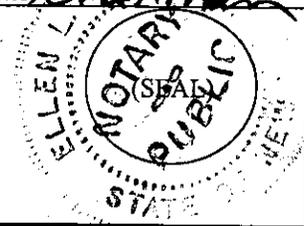
- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political subdivision.
That accountability and reporting of these funds shall be in accordance with the requirements set forth by the Local Government Division of the New Mexico Department of Finance and Administration.
That the funds distributed under the Act will not supplant other funds budgeted and designated for emergency medical service purposes.

Signature of Official Named Above (Handwritten signature of Franklin McCasland)

(Title) Chairman (Handwritten)

The above was sworn and subscribed to before this 7 day of January, 2019

Notary Public: (Handwritten signature) My commission expires: 3-21-19



PERSON COMPLETING FORM

Name: Paula O'Steen, EMS Director
Address: PO Box 643, Tucumcari, NM 88401 0643
(575) 487-2002, N/A, N/A, (575) 760-7961, osteenp2000@yahoo.com
Signature: Paula O'Steen

FOR BUREAU USE ONLY

Reviewer: Date Reviewed:
Approved: Yes No Final Award:
Comments/Problem:
Date Corrected:

## Equipment Inventory Report

The following equipment and disposable supplies are required by the Public Regulation Commission and the Medical Rescue Certification regulations. Items that are missing, broken or depleted should be considered as top priority items for funding requests. (Please indicate below the number of items "on hand")

### Front of Vehicle Cab or Optimal Location:

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 -- 11lb)	2	Siren	Yes
Flashlight	2	Spare Tire	1
Fuses (appropriate sizes)		Star of Life Displayed	Yes
Jack and Handle	1	Tool Box	1
Lug Wrench	1	Triage Tags for MCI's	Yes
Maps or Navigational equipment	1	U.S. DOT Emergency Response Guidebook	Yes
Patient Care Reports or Reporting System	Yes	Vehicle Registration	Yes
Roadway warning devices	8	Vehicle Spotlight or auxiliary lighting	Yes
Service Specific Protocols and guidelines	Yes	Warning Lights	Yes
Other: <i>(Specify)</i>			

### Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	1	Spare Batteries/charger system	
EMSCOM (UHF) Radio	1		
Other: <i>(Specify)</i>			

### Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	Asst Sizes	Helmet with Face Shield	
Eye Protection	Yes	N-95 mask (or > particulate mask)	6
Gloves (Leather or heavy duty)		Safety Vest/Jacket/(ANSI 2008 Compliant)	2
Hearing Protection		Splash Protection (disposable)	
Other: <i>(Specify)</i>			

## Diagnostic Equipment

Item Description	On Hand	Item Description	On Hand
Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs	1 Set		
Entitled CO2 monitoring device (optional)		Pulse Oximeter	2
Glucose Monitoring Instrument	2	Stethoscope	4
Penlights	4	Thermometer (Patient)	1
Other: <i>(Specify)</i>			

## Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	12	Oxygen Delivery Devices (Adult, Child and Infant Sizes)	Assorted
Auto Ventilator Devices (ATV/MTV)		Oxygen Supply Tubing	4
Bag Valve Mask Devices (Adult, Child and Infant)	1 Each	Patient Restraints	
Band-Aids (Assorted Sizes)	1 Box	Pediatric Drug Dosage Tape or chart	2
Biohazard Clean-up Supplies	Yes	Pediatric Restraint device/car seat	1
Biohazard Waste bags	50	Pillows	2
Blankets	4	Portable Oxygen Equipment	2
Body Bags	1	Portable Suction Unit	2
Cervical Collars - Rigid (Adult, Child and Infant)	2 Each	Seated Spinal Immobilization Device	1
Cervical Immobilization Devices	12	Semi-Automatic Defibrillator with Pads	1
Chair Stretcher		Semi-Automatic Defibrillator Batteries	
Cold Pack	12	Sharps Container	3
Cold Weather Warming Devices	12	Sheets	20
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	12 Each	Shoulder/chest/extremity straps	1
Emesis Basin	2	Spinal Immobilization device/backboard	4
Field Stretcher (Scoop, Collapsible, Vacuum)	1	Splints, Extremity (Rigid, Air, Vacuum)	Assorted
Foil Blanket		Sterile Burn Sheets	1
Hand Sanitizer	Yes	Sterile Gloves (Assorted Sizes)	12
Heat Pack	12	Sterile Water	12
Inhalation Therapy Equipment	4	Stokes Basket	
Installed Oxygen System	1	Suction Catheters (Soft & Rigid)	2
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	2 Boxes Each	Supraglottic Airway Devices	
Long Backboard	4	Multi-lumen Airway Devices	2
Multi-level Stretcher	1	Laryngeal Airway Devices	
Multi-Lumen Airways	2	Towels	1
Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2	Traction Splint	1
Nasopharyngeal Airways	3 Sets	Trauma Dressings	12
Occlusive Dressings	12	Trauma Shears	3
On-Board Suction System	1	Triangular Bandages	12
On-Board Oxygen Supply	1	Urinal (Male and Female)	4
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	3 Sets		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for First Responder, EMT-Basic and the Service Medical Director			(Circle) Yes No

Other: <i>(Specify)</i>			
<b>Advance Level</b>			
Alcohol and Betadine Prep Pads	100	IV Fluid (Normal Saline, D5W, LR)	8
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)		Laryngoscope Blades – Adult	
Chest Decompression Catheters		Laryngoscope Blades –Peds	
Cricothyroidotomy Kit		Laryngoscope Handle	
EKG Monitor Electrodes		Magill Forceps	
Electrode Defib Pads		Needles (Assorted Gauges)	Yes
		Pediatric Fluid Control Device	1
Endotracheal Tubes (Assorted)		Scalpels	
Ext. Cardiac Pacing Pads		Syringes (1cc, 3cc, 5cc, 10cc)	Assorted
Infusion Pumps		Toomey Syringe (60cc)	
Inhalation Therapy Equipment	4	Tubes, Blood Drawing (Assorted Sizes and Types)	Yes
Intraosseous Needles	1	Tubing, IV Administration (60gts)	
IV Catheters	Yes	Tubing, IV Administration Set (10gts – 20gts)	4
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Intermediate and EMT- Paramedic, and the Service Medical Director			(Circle) Yes No
Other: <i>(Specify)</i>			



**EMS FUND ACT  
LOCAL FUNDING PROGRAM  
APPLICATION  
FISCAL YEAR 2020**

Submit to:  
EMS Bureau  
1301 Siler Rd Bldg F  
Santa Fe, NM 87507  
Attn: Ann Martinez 505-476-8233

**Due Date: January 25, 2019**

**To All Potential Applicants:**

The EMS Fund Act was created for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life.

In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution. **To be eligible**, an applicant must be an incorporated municipality or county applying on behalf of a **local recipient** (publicly owned or contracted ambulance or air ambulance service, medical rescue service, fire department rescue service, regionalized emergency medical service agency; or other prehospital emergency medical service care provider based in state). Your service must also be compliant with NMEMSTARS Data V.3 Elite, and Medical Rescue Certification, if not a PRC Service. **NOTE: You must be transitioning over to V.3 by December 1, 2018 and contacted the EMS Bureau of your transfer.**

Your Application and Annual Report **must be postmarked or hand-delivered** to the EMS Bureau by **5:00pm on Friday, January 25, 2019**. Please adhere to the following instructions, as **incomplete applications will not be processed**:

- Submit an **ORIGINAL AND THREE (3) COPIES – Annual Service Report as well. Failure to make copies will result in an incomplete application and will not be accepted.** (faxed or emailed applications will not be accepted as well)
- **NO SPECIAL BINDING** (*one staple in the left top corner only- NO PAPERCLIPS or BINDERS*)
- **Be sure to have necessary SIGNATURES and NOTARY.**

<b>Local Recipient:</b>	Bard-Endee Fire District			321340	
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>	
<b>Mailing Address:</b>	1097 Route 66		Bard		NM 88411
	<i>(Street/Mailing Address)</i>		<i>(City)</i>		<i>(State) (Zip)</i>
	1	2	X	3	575.576.2233
	<i>(EMS Region)</i>		<i>(Business Phone #)</i>		<i>(Emergency Phone #)</i>
<b>Contact Person:</b>	Donald Adams		Fire Chief		quaycofm@yahoo.com
	<i>(Name)</i>		<i>(Title)</i>		<i>(E-mail Address)</i>

<b>Applicant:</b>	Quay County
	<i>(County or Municipality serving as Fiscal Agent)</i>

<b>Mailing Address:</b>	P.O. Box 1246	Tucumcari	NM	88401
	<i>(Mailing Address)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	Richard Primrose	County Manager		
	<i>(Name)</i>	<i>(Title)</i>		
	575-461-2112	575.461.6208	richard.primrose@quaycounty.nm v	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

### EMS AGENCY FUNDING INFORMATION

The minimum distribution of funds is based on the following criteria. Assure the agency meets each criterion for the level for which the agency is applying. If each box under a particular level cannot be checked off, the applying service may not be eligible to receive EMS Fund Act funds. Choose one (1) level for which your service meets or exceeds the criteria. (All responses are subject to review and verification).

Medical-Rescue Service Entry Level  (\$1,500)	Medical-Rescue Service First Responder  (\$3,000)	Medical-Rescue Service/Ambulance Basic Level  (\$5,000)	Medical-Rescue Service/Ambulance Advance Level  (\$7,000)
<input type="checkbox"/> <b>Check if applicable</b> Fifty percent (50%) of all runs are covered by a NM licensed First Responder (within two years of the initial request for funding).	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs are covered by a NM licensed First Responder or NM licensed EMT, <u>minimum of two NM licensed personnel.</u>	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, <u>minimum of two NM licensed personnel.</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-I or EMT-P level, <u>minimum of two NM licensed personnel.</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has Basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.
<input type="checkbox"/> <b>Check if applicable</b> The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> <b>Check if applicable</b> Service plans to routinely respond (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS medical protocols.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations

Check if applicable

If applicable, Service complies with Air Ambulance certification regulations 7.27.5 NMAC.

### LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

- Please complete the Equipment Inventory Report prior to listing your funding requests.
- Funds may only be utilized to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical personnel. Please round all estimated costs to the nearest \$100. We must be realistic, please estimate amount closest to funding that service receives every year.
- Use each number only once. (Use additional sheets if necessary.)

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
<b>Repair and Maintenance:</b>		
<b>Training:</b>		
<b>Mileage &amp; Per Diem:</b>		
<b>Supplies (Items Under \$500):</b>		
<b>**Capital Outlay (Items Over \$500):</b>		
3	Battery operated combination tool for Rescues	5000
	Item costs over \$13,000. Fire Funds will be used to finish paying for the tool.	
<b>Other Operational Costs:</b>		
1	AED	1300
2	Batteries and Pads for existing AED	750





<b>Name:</b>	Kelly Boney		EMT	
	<i>(Name)</i>		<i>(Title)</i>	
<b>Address:</b>	1097 Route 66			
	Bard	NM	88411	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
575-602-5888				
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>	<i>Kelly Boney</i>			

**FOR BUREAU USE ONLY**

Reviewer: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Approved:      Yes                  No                  Final Award: \_\_\_\_\_

Comments/Problem:

Date Corrected:

## Equipment Inventory Report

The following equipment and disposable supplies are required by the Public Regulation Commission and the Medical Rescue Certification regulations. Items that are missing, broken or depleted should be considered as **top priority** items for funding requests. (Please indicate below the number of items "on hand") **Front of Vehicle Cab or Optimal Location:**

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 – 11lb)	X	Siren	X
Flashlight	X	Spare Tire	
Fuses (appropriate sizes)	X	Star of Life Displayed	X
Jack and Handle		Tool Box	X
Lug Wrench	X	Triage Tags for MCI's	X
Maps or Navigational equipment	X	U.S. DOT Emergency Response Guidebook	X
Patient Care Reports or Reporting System	X	Vehicle Registration	X
Roadway warning devices	X	Vehicle Spotlight or auxiliary lighting	X
Service Specific Protocols and guidelines	X	Warning Lights	X
Other: <i>(Specify)</i>			

### Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	X	Spare Batteries/charger system	X
EMSCOM (UHF) Radio	X		
Other: <i>(Specify)</i>			

### Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	3 Sizes	Helmet with Face Shield	3
Eye Protection	2	N-95 mask (or > particulate mask)	2
Gloves (Leather or heavy duty)	3	Safety Vest/Jacket/(ANSI 2008 Compliant)	4

Hearing Protection	2	Splash Protection (disposable)	2
Other: <i>(Specify)</i>			

### Diagnostic Equipment

Item Description	On Hand	Item Description	On Hand
Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs	1		
Entitled CO2 monitoring device (optional)	0	Pulse Oximeter	1
Glucose Monitoring Instrument	1	Stethoscope	2
Penlights	3	Thermometer (Patient)	2
Other: <i>(Specify)</i>			

### Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	4	Oxygen Delivery Devices (Adult, Child and Infant Sizes)	2
Auto Ventilator Devices (ATV/MTV)	0	Oxygen Supply Tubing	5
Bag Valve Mask Devices (Adult, Child and Infant)	2	Patient Restraints	1
Band-Aids (Assorted Sizes)	2 boxes	Pediatric Drug Dosage Tape or chart	1
Biohazard Clean-up Supplies	4	Pediatric Restraint device/car seat	1
Biohazard Waste bags	10	Pillows	1
Blankets	5	Portable Oxygen Equipment	1
Body Bags	2	Portable Suction Unit	1
Cervical Collars - Rigid (Adult, Child and Infant)	2 each size	Seated Spinal Immobilization Device	1
Cervical Immobilization Devices	2	Semi-Automatic Defibrillator with Pads	1

Chair Stretcher	1	Semi-Automatic Defibrillator Batteries	1
Cold Pack	5	Sharps Container	2
Cold Weather Warming Devices	3	Sheets	1Box
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	3Boxes of ea	Shoulder/chest/extremity straps	1
Emesis Basin	6	Spinal Immobilization device/backboard	4
Field Stretcher (Scoop, Collapsible, Vacuum)	1	Splints, Extremity (Rigid, Air, Vacuum)	1
Foil Blanket	3	Sterile Burn Sheets	3
Hand Sanitizer	1	Sterile Gloves (Assorted Sizes)	1 box each size
Heat Pack	5	Sterile Water	10
Inhalation Therapy Equipment		Stokes Basket	1
Installed Oxygen System	0	Suction Catheters (Soft & Rigid)	3
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	3 Boxes	Supraglottic Airway Devices	1set
Long Backboard	2	Multi-lumen Airway Devices	1
Multi-level Stretcher		Laryngeal Airway Devices	
Multi-Lumen Airways		Towels	20
Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	1	Traction Splint	1
Nasopharyngeal Airways	1set	Trauma Dressings	Multiple
Occlusive Dressings	3	Trauma Shears	5
On-Board Suction System		Triangular Bandages	5
On-Board Oxygen Supply		Urinal (Male and Female)	1
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	1 set		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for First Responder, EMT-Basic and the Service Medical Director			(Circle) Yes No
Other: <i>(Specify)</i>			
<b>Advance Level</b>			
Alcohol and Betadine Prep Pads	Box	IV Fluid (Normal Saline, D5W, LR)	
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)		Laryngoscope Blades -- Adult	
Chest Decompression Catheters		Laryngoscope Blades --Peds	
Cricothyroidotomy Kit		Laryngoscope Handle	
EKG Monitor Electrodes		Magill Forceps	
Electrode Defib Pads		Needles (Assorted Gauges)	
		Pediatric Fluid Control Device	

Endotracheal Tubes (Assorted)		Scalpels	
Ext. Cardiac Pacing Pads		Syringes (1cc, 3cc, 5cc, 10cc)	
Infusion Pumps		Toomey Syringe (60cc)	
Inhalation Therapy Equipment		Tubes, Blood Drawing (Assorted Sizes and Types)	
Intraosseous Needles		Tubing, IV Administration (60gtts)	
IV Catheters		Tubing, IV Administration Set (10gtts – 20gtts)	
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMTIntermediate and EMT- Paramedic, and the Service Medical Director			(Circle) Yes No
Other: <i>(Specify)</i>			



**EMS ANNUAL SERVICE REPORT**  
**Fiscal Year 2020**  
 Due Date: January 25, 2019

Submit to:  
 EMS Bureau  
 1301 Siler Rd Bldg. F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

<b>Service Name:</b>	Bard-Endee Fire District
	<i>(EMS Service)</i>

<b>Mailing Address:</b>	1097 Route 66			
	<i>(Mailing Address)</i>			
	Bard	NM	88411	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	Fire Chief			
	<i>(Title)</i>			
	575-576-2233	575-403-7911		quaycofm@yahoo.com
	<i>(Business Phone)</i>	<i>(Emergency Phone)</i>	<i>(Fax)</i>	<i>(E-mail Address)</i>
<b>Administration:</b>	Quay County			
	<i>(County or Municipality)</i>			
	P.O. Box 1246			
	<i>(Mailing Address)</i>			
	Tucumcari	NM	88401	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	Richard Primrose		County Manager	
	<i>(Name)</i>		<i>(Title)</i>	
<b>Contact Person:</b>	575-461-2112	575-461-6208	richard.primrose@quaycounty-nm.gov	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	
<b>EMS Region:</b>	<b>Region I</b>	<b>Region II</b>	<b>Region III</b>	X

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Bard Station			
	N 35.114394	W 103.207606		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	1097 Route 66			
	Bard	NM	88411	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>	Endee Station			
	N 35.164762	W 103.104268		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	325State HWY 392			

<b>Service Name:</b>	Bard-Endee Fire District			
	<i>(EMS Service)</i>			
	Bard	NM	88411	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<i>(Use additional pages as necessary)</i>				

<b>SERVICE INFORMATION</b>					
<b>Type of Service (Must Check Only One)</b>			<b>Affiliation Type (Mark Primary Affiliation Only)</b>		
<input type="checkbox"/>	Certified PRC Ambulance		Private for-profit with a County or Municipality Contract		
<input checked="" type="checkbox"/>	Certified Medical/Rescue Service (Non-transport)		Private non-profit with a County or Municipality Contract		
<input type="checkbox"/>	Certified Medical/Rescue Service (Transport Capable)		<input checked="" type="checkbox"/>	Fire Dept.-based	
<input type="checkbox"/>	Emergency Medical Dispatch Agency		Law Enforcement or Department of Public Safety-based		
<input type="checkbox"/>	Special Event(s) Agency		Clinic-based		
<input type="checkbox"/>	Air Ambulance with a County or Municipality Contract		Hospital-based		
<input type="checkbox"/>	Other (Please Specify):		County-based		
<input type="checkbox"/>			Municipality-based		
<input type="checkbox"/>	PRC Certification #		Tribal		
<input type="checkbox"/>	Medical Rescue Certification #	311340	Other (Please Specify):		
<input type="checkbox"/>					
<b># of Years in Operation</b>	36				
<b>EMS Calls</b>			<b>Local Receiving Hospital(s)</b>		
<b>Received By (Mark One)</b>		<b>Dispatched by (Mark One)</b>		Dan C. Trigg	
<input type="checkbox"/>	Basic 911	<input type="checkbox"/>	Ambulance Service	<input type="checkbox"/>	Central Dispatch
<input checked="" type="checkbox"/>	Enhanced 911	<input type="checkbox"/>	Fire Department	Location of Dispatch:	
<input type="checkbox"/>	Local Phone	<input type="checkbox"/>	Law Enforcement		

<b>EMERGENCY MEDICAL SERVICES PERSONNEL</b>					
<b>LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL</b>					
	Paid (Indicate Part Time/Full Time)	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder			Emergency Medical Dispatch Instructor		
EMT Basic		2	Nurse		
EMT Intermediate		1	Physician		
EMT Paramedic			Driver		
Emergency Medical Dispatcher			Other		

\*Volunteer may include those paid by the run or other non-salary arrangement.

<b>Service Name:</b>	Bard-Endee Fire District
	(EMS Service)

**LICENSED EMS PERSONNEL**

List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. *(Use additional pages as necessary.)*

Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Dale L Bone	B	00025807	3/31/2021	2014	V
Barton Bone	B	18000700	3/31/2021	2014	V
Kelly L Boney	I	14000126	3-31-2019	2014	V



<b>Service Name:</b>	Bard-Endee Fire District
	<i>(EMS Service)</i>

**For Ground Ambulance/Medical Rescue Services Only**

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)**

List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)

Name	Driver's License Number and State	EVOC Course Date	Class of NMDL	Other Medical Training
Don McCoy	006289614	2000	CDL	Past EMT
Donald Carter	001180649	2000	CDL	Past EMT
Wade Lane	051306554	2000	E	Past EMT
Donald Adams	00574503	2000	E	Past EMT
Austin Gibson	503782413	2014	E	CPR

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLES**

Enter the total number of each type of vehicle used by your service. *(Mandatory)*

Type I:		Type IV:	
Type II:		Medical/Rescue:	X
Type III:		Other – Explain:	

List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four-wheel drive, patient capacity for supine patients, and the current mileage. *(Mandatory) (Use additional pages as necessary)*

Year	Make And Model	Type of Vehicle	License Number	State Assigned EMSCOM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
1996	Ford	Brush Truck	G24015	#4	11-96	4WD	0	11253	2018
1979	IHC	Rescue	G63259	#8	2-1979	2WD	0	7120	2018
2007	Ford	Brush Truck	G71893	#10	3-2007	4WD	0	7216	2018
2008	Peterbuilt	Engine	G75110	#12	1-7-2008	4WD	0	3798	2018
2010	IHC	Engine	F81419	#13	3-2010	4WD	0	3798	2018

<b>Service Name:</b>	Bard-Endee Fire District												
	<i>(EMS Service)</i>												
<i>(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)</i>													
<b>VEHICLE PREVENTIVE MAINTENANCE PROGRAM</b>													
1. Do you have a Vehicle Preventive Maintenance Program in place?										<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a copy of your program.													
2. Indicate the frequency of vehicle inspections:				<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input checked="" type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly		
3. Attach Annual Safety Inspection for all units. (PRC ONLY)													

<b>OPERATIONS PLAN</b>													
Please provide information on the Operations Plan for your service.													
1. Do you have an Operations Plan?										<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are operational and medical protocols included in the Operations Plan?										<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. What was the effective date of your Operations Plan?							<b>Updated 6-6-2015</b>						
4. Please provide a map of the coverage area for your service.													

<b>QUALITY ASSURANCE REVIEW</b>													
1. Do you have an internal quality assurance/improvement mechanism in place?										<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a brief description.													
2. Indicate the dates of this year's quality assurance review activities.													
Reviews are conducted:			<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly	<input checked="" type="checkbox"/>	Annually	
<b>DATES OF REVIEW</b>													
DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	
December 2018													

<b>SERVICE DIRECTOR/CHIEF</b>										
<b>Name:</b>	Donald Adams					Fire Chief				
	<i>(Name)</i>					<i>(Title)</i>				
<b>Address:</b>	1097 Route 66				Bard	NM	88411			
	<i>(Street/Mailing)</i>				<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>			

<b>Service Name:</b>	Bard-Endee Fire District			
	(EMS Service)			
575-403-7911	576-2210			gunyc@fm@yahoo.com
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	Donald Oelmu			

SERVICE MEDICAL DIRECTOR				
<b>Name:</b>	Dr. George Evetts, MD	MD	60-36NM	
	(Name)	(Title)	(License #)	
<b>Address:</b>	916 W. Escuela Ave	Tucumcari	NM	88404
	(Street/Mailing)	(City)	(State)	(Zip)
575-461-0591			gevetts@sr66.com	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</b>				
<b>*Signature:</b>	George Evetts MD			

SERVICE TRAINING COORDINATOR				
<b>Name:</b>	Kelly Boney	Training Coordinator	14000126	AEMT
	(Name)	(Title)	(License #)	(Level)
<b>Address:</b>	1097 Route 66	Bard	NM	88411
	(Street/Mailing)	(City)	(State)	(Zip)
		575-602-5888	Kellyboney_79@yahoo.com	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	Kelly Boney			

PERSON COMPLETING FORM				
<b>Name:</b>	Kelly Boney	EMT		
	(Name)	(Title)		
<b>Address:</b>	1097 Route 66	Bard	NM	88411
	(Street/Mailing)	(City)	(State)	(Zip)
575-602-5888			kellyboney_79@yahoo.com	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	Kelly Boney			

<b>Service Name:</b>	Bard-Endee Fire District
	(EMS Service)

The above was sworn and subscribed to before this 2nd Day of JANUARY, 2019

Sheryl Chambers  
Notary Public

08/19/2019  
My Commission Expires



\*\*\*\* Notary is for the person completing form



**EMS ANNUAL SERVICE REPORT**  
**Fiscal Year 2020**  
 Due Date: January 25, 2019

Submit to:  
 EMS Bureau  
 1301 Siler Rd Bldg. F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

<b>Service Name:</b>	<b>Forrest</b> <i>(EMS Service)</i>
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<b>Mailing Address:</b>	209 State highway 210 <i>(Mailing Address)</i>			
	Melrose <i>(City)</i>	NM <i>(State)</i>	88124 <i>(Zip)</i>	 <i>(+4)</i>
<b>Contact Person:</b>	Joe A. Garrett <i>(Name)</i>		EMS Coordinator <i>(Title)</i>	
	575-309-9065 <i>(Business Phone)</i>	575-799-4879 <i>(Emergency Phone)</i>	 <i>(Fax)</i>	Pappyjoe63.jg@gmail.com <i>(E-mail Address)</i>
<b>Administration:</b>	Quay County <i>(County or Municipality)</i>			
	PO Box 1246 <i>(Mailing Address)</i>			
	Tucumcari <i>(City)</i>	NM <i>(State)</i>	88401 <i>(Zip)</i>	1246 <i>(+4)</i>
<b>Contact Person:</b>	Richard Primrose <i>(Name)</i>		County Manager <i>(Title)</i>	
	(575) 461-2112 <i>(Telephone #)</i>	(575) 461-6208 <i>(Fax Phone #)</i>	richard.primrose@quaycounty-nm.gov <i>(E-mail Address)</i>	
<b>EMS Region:</b>	<b>Region I</b>	<b>Region II</b>	<b>Region III</b>	<b>X</b>

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Forrest Fire Department			
	34.794682 <i>Latitude</i>		103.601018 <i>Longitude</i>	
<b>Street Address:</b>	209 State Highway 210			
	McAlister <i>(City)</i>	NM <i>(State)</i>	88427 <i>(Zip)</i>	 <i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>				
	<i>Latitude</i>		<i>Longitude</i>	
<b>Street Address:</b>				
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<i>(Use additional pages as necessary)</i>				

<b>Service Name:</b>	Forrest (EMS Service)
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SERVICE INFORMATION			
Type of Service (Must Check Only One)		Affiliation Type (Mark Primary Affiliation Only)	
<input type="checkbox"/>	Certified PRC Ambulance	<input type="checkbox"/>	Private for-profit with a County or Municipality Contract
<input type="checkbox"/>	Certified Medical/Rescue Service (Non-transport)	<input type="checkbox"/>	Private non-profit with a County or Municipality Contract
<input checked="" type="checkbox"/>	Certified Medical/Rescue Service (Transport Capable)	<input checked="" type="checkbox"/>	Fire Dept.-based
<input type="checkbox"/>	Emergency Medical Dispatch Agency	<input type="checkbox"/>	Law Enforcement or Department of Public Safety-based
<input type="checkbox"/>	Special Event(s) Agency	<input type="checkbox"/>	Clinic-based
<input type="checkbox"/>	Air Ambulance with a County or Municipality Contract	<input type="checkbox"/>	Hospital-based
<input type="checkbox"/>	Other (Please Specify):	<input type="checkbox"/>	County-based
<input type="checkbox"/>		<input type="checkbox"/>	Municipality-based
<input type="checkbox"/>		<input type="checkbox"/>	Tribal
<b>PRC Certification #</b>		<b>Medical Rescue Certification #</b>	321329
		<b>Other (Please Specify):</b>	
<b># of Years in Operation</b>	9		
EMS Calls		Local Receiving Hospital(s)	
<b>Received By (Mark One)</b>	<b>Dispatched by (Mark One)</b>	Dan C Trigg Hospital	
<input type="checkbox"/>	Basic 911	<input type="checkbox"/>	Ambulance Service
<input checked="" type="checkbox"/>	Enhanced 911	<input checked="" type="checkbox"/>	Central Dispatch
<input type="checkbox"/>	Local Phone	<input type="checkbox"/>	Law Enforcement
		PRMC Clovis	
		Location of Dispatch:	

EMERGENCY MEDICAL SERVICES PERSONNEL					
LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL					
	Paid (Indicate Part Time/Full Time)	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder		2	Emergency Medical Dispatch Instructor		
EMT Basic		3	Nurse		
EMT Intermediate		1	Physician		
EMT Paramedic			Driver		4
Emergency Medical Dispatcher			Other		

\*Volunteer may include those paid by the run or other non-salary arrangement.

LICENSED EMS PERSONNEL					
List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. (Use additional pages as necessary.)					
Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Rick Mitchell	EMT-I	00025805	03/31/2020	10/2017	Volunteer
Joe Garrett	EMT-Basic	10001526	03/31/2019	10/2017	Volunteer
Joe Lavender	EMT-Basic	10001459	03/31/2019	10/2017	Volunteer
Denise Runyan	EMT-Basic	1600190	03/31/2020	10/2017	Volunteer
Jeri Rush	EMT - FR	00017372	03/31/2019	10/2017	Volunteer
David Rush	EMT-FR	00024736	03/31/2019	10/2017	Volunteer





Service Name:	Forrest
	(EMS Service)

VEHICLE PREVENTIVE MAINTENANCE PROGRAM				
1. Do you have a Vehicle Preventive Maintenance Program in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a copy of your program.				
2. Indicate the frequency of vehicle inspections:	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly
	<input checked="" type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
3. Attach Annual Safety Inspection for all units. (PRC ONLY)				

OPERATIONS PLAN				
Please provide information on the Operations Plan for your service.				
1. Do you have an Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are operational and medical protocols included in the Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. What was the effective date of your Operations Plan?	10/2010			
4. Please provide a map of the coverage area for your service.				

QUALITY ASSURANCE REVIEW				
1. Do you have an internal quality assurance/improvement mechanism in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a brief description.				
2. Indicate the dates of this year's quality assurance review activities.				
Reviews are conducted:	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly
	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
	<input checked="" type="checkbox"/>	Annually		
DATES OF REVIEW				
DATE	DATE	DATE	DATE	DATE
July 2018				

SERVICE DIRECTOR/CHIEF				
Name:	Joe G. Lavender		Chief	
	(Name)		(Title)	
Address:	209 State Highway 210		McAlister	NM 88427
	(Street/Mailing)		(City)	(State) (Zip)
575-799-4879	575-458-6312	Forrest 602	Joegl987@gmail.com	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
Signature:				

Service Name:	Forrest (EMS Service)
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SERVICE MEDICAL DIRECTOR				
Name:	George E Evetts (Name)	Medical Director (Title)	60-36 NM (License #)	
Address:	PO Box 1128 (Street/Mailing)	Tucumcari (City)	NM (State)	88401 (Zip)
(Work Phone)	(575) 461-0591 (Home Phone #)	(Pager #)	(Cellular Phone #)	gevetts@sr66.com (E-mail Address)
<b>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</b>				
*Signature:	<i>George E Evetts</i>			

SERVICE TRAINING COORDINATOR				
Name:	Joe A. Garrett (Name)	EMS coordinator (Title)	10001526 (License #)	EMT -B (Level)
Address:	3298 Quay Road 37 (Street/Mailing)	Melrose (City)	NM (State)	88124 (Zip)
(Work Phone)	575-309-9065 (Home Phone #)	Forrest 605 (Pager #)	575-309-9065 (Cellular Phone #)	Pappyjoe63.jg@gmail.com (E-mail Address)
Signature:	<i>Joe A. Garrett</i>			

PERSON COMPLETING FORM				
Name:	Joe A. Garrett (Name)	EMS Coordinator (Title)		
Address:	3298 Quay Road 37 (Street/Mailing)	Melrose (City)	NM (State)	88124 (Zip)
(Work Phone)	575-309-9065 (Home Phone #)	Forrest 605 (Pager #)	575-309-9065 (Cellular Phone #)	Pappyjoe63.jg@gmail.com (E-mail Address)
Signature:	<i>Joe A. Garrett</i>			

The above was sworn and subscribed to before this 8th Day of January, 2019

*Ellen L White*  
Notary Public

3-21-19  
My Commission Expires



\*\*\*\* Notary is for the person completing form



**EMS FUND ACT  
LOCAL FUNDING PROGRAM  
APPLICATION  
FISCAL YEAR 2020**

Submit to:  
EMS Bureau  
1301 Siler Rd Bldg F  
Santa Fe, NM 87507  
Attn: Ann Martinez  
505-476-8233

**Due Date: January 25, 2019**

**To All Potential Applicants:**

The EMS Fund Act was created for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life.

In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution. **To be eligible**, an applicant must be an incorporated municipality or county applying on behalf of a **local recipient** (publicly owned or contracted ambulance or air ambulance service, medical rescue service, fire department rescue service, regionalized emergency medical service agency; or other prehospital emergency medical service care provider based in state). Your service must also be compliant with NMEMSTARS Data V.3 Elite, and Medical Rescue Certification, if not a PRC Service. **NOTE: You must be transitioning over to V.3 by December 1, 2018 and contacted the EMS Bureau of your transfer.**

Your Application and Annual Report **must be postmarked or hand-delivered** to the EMS Bureau by **5:00pm on Friday, January 25, 2019**. Please adhere to the following instructions, as **incomplete applications will not be processed:**

- Submit an **ORIGINAL AND THREE (3) COPIES – Annual Service Report as well. Failure to make copies will result in an incomplete application and will not be accepted.** (faxed or emailed applications will not be accepted as well)
- **NO SPECIAL BINDING** (*one staple in the left top corner only- NO PAPERCLIPS or BINDERS*)
- Be sure to have necessary **SIGNATURES** and **NOTARY**.

<b>Local Recipient:</b>	Forrest			321329		
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>		
<b>Mailing Address:</b>	209 State Highway 210		McAlister		NM	88427
	<i>(Street/Mailing Address)</i>		<i>(City)</i>		<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	1	2	X	3	575-309-9065	575-799-4879
	<i>(EMS Region)</i>		<i>(Business Phone #)</i>		<i>(Emergency Phone #)</i>	
	Joe G. Lavender			Chief		Joegl387@gmail.com
	<i>(Name)</i>			<i>(Title)</i>		<i>(E-mail Address)</i>

<b>Applicant:</b>	Quay County					
	<i>(County or Municipality serving as Fiscal Agent)</i>					
<b>Mailing Address:</b>	Po Box 1246		Tucumcari		NM	88401
	<i>(Mailing Address)</i>		<i>(City)</i>		<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	Richard Primrose			Quay County Manager		
	<i>(Name)</i>			<i>(Title)</i>		
	575-461-2112		575-461-6208		richardquay@plateautel.net	
	<i>(Telephone #)</i>		<i>(Fax Phone #)</i>		<i>(E-mail Address)</i>	

## EMS AGENCY FUNDING INFORMATION

The minimum distribution of funds is based on the following criteria. Assure the agency meets **each** criterion for the level for which the agency is applying. **If each box under a particular level cannot be checked off, the applying service may not be eligible to receive EMS Fund Act funds.** Choose **one (1) level** for which your service meets or exceeds the criteria.  
**(All responses are subject to review and verification).**

Medical-Rescue Service Entry Level  ( <b>\$1,500</b> )	Medical-Rescue Service First Responder  ( <b>\$3,000</b> )	Medical-Rescue Service/Ambulance Basic Level ( <b>\$5,000</b> )	Medical-Rescue Service/Ambulance Advance Level ( <b>\$7,000</b> )
<input type="checkbox"/> <b>Check if applicable</b> Fifty percent ( <b>50%</b> ) of all runs are covered by a NM licensed First Responder (within two years of the initial request for funding).	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent ( <b>80%</b> ) of all runs are covered by a NM licensed First Responder or NM licensed EMT, <b>minimum of two NM licensed personnel.</b>	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent ( <b>80%</b> ) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, <b>minimum of two NM licensed personnel.</b>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Eighty percent ( <b>80%</b> ) of all runs covered by a NM licensed EMT-I or EMT-P level, <b>minimum of two NM licensed personnel.</b>
<input type="checkbox"/> <b>Check if applicable</b> Service has Basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <b>Attached copy(s)</b>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <b>Attached copy(s)</b>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <b>Attach copy(s)</b>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <b>Attach copy(s)</b>
<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.
<input type="checkbox"/> <b>Check if applicable</b> The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> <b>Check if applicable</b> Service plans to routinely respond ( <b>defined as "available...24 hours per day, 7 days per week"</b> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <b>defined as "available...24 hours per day, 7 days per week"</b> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <b>defined as "available...24 hours per day, 7 days per week"</b> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <b>defined as "available...24 hours per day, 7 days per week"</b> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS medical protocols.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations
			<input type="checkbox"/> <b>Check if applicable</b> If applicable, Service complies with Air Ambulance certification regulations 7.27.5 NMAC.

## LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

- Please complete the Equipment Inventory Report prior to listing your funding requests.
- Funds may only be utilized to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical personnel. Please round all estimated costs to the nearest \$100. We must be realistic, please estimate amount closest to funding that service receives every year.
- Use each number only once. (Use additional sheets if necessary.)

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
<b>Repair and Maintenance:</b>		
1	Regular maintenance and service on Rescue unit	2000
2	Calibration on equipment and yearly service	1000
<b>Training:</b>		
1	Renewal and refresher training to keep up with changes	1200
<b>Mileage &amp; Per Diem:</b>		
1	Mileage to attend trainings in the surrounding area	600
<b>Supplies (Items Under \$500):</b>		
1	One time use supplies	300
2	Replace expired supplies	300
3	Cleaning and disinfectant supplies	100
<b>**Capital Outlay (Items Over \$500):</b>		
1	Proper climate controlled area for Rx supplies	800
<b>Other Operational Costs:</b>		
11	Pharmacist	300
2	Fuel	500
<b>TOTAL AMOUNT OF REQUEST:</b>		<b>7100</b>

\* Do not make all items Priority No. 1.

\*\* For **Capital Outlay Projects** for which the service intends to "carry over" funds for multiple years in order to pay for a particularly expensive item, the following criteria must be documented and/or met:

- Maximum number of years for single project is 3 - 5 years
- Item and savings plan must be described, including amount designated for item each year
- Carry over request for designated project money must accompany the required end of year fiscal year expenditure report
- Amount of project designated money for the year and carry-over request amount must match
- 

**Note:** If project changes, the designated project money must be returned unless bureau approval for other expenditure is Obtained ( Communication is key here )

## JUSTIFICATION OF TOP PRIORITIES

Please justify your priorities on this application in accordance with the type and level of service you provide and the resources and capabilities of other EMS services in the area. Why are these top priorities? (Use additional sheets if necessary.)

Service of the equipment and regular scheduled maintenance is a top priority with in the Forrest Department, With are goal being able to respond to any type of emergency in a safe manner as needed.

Are equipment needs to be serviced and calibrated for, a proper slandered of operation

If we don't help our Volunteers with training ang mileage to attend trainings, it could put a financial strain

On our people, we need training to stay aware of changes and experience others have gone thru.

Our funds will be utilized to keep us at a safe and proper standered of iperations

SERVICE NAME: \_\_\_\_\_

**EMS FUND ACT CERTIFICATION BY APPLICANT**

STATE OF NEW MEXICO, COUNTY OF \_\_\_\_\_ QUAY

Pursuant to the Emergency Medical Services Fund Act Program 7.27.4 NMAC, I the undersigned:  
(TYPE OR PRINT)

Mayor OR Chairman, Board of Commissioners

Municipality County

I do certify that the information contained in the application is true and correct to the best of my knowledge and information; and that the following specific conditions are satisfactorily met in accordance with the EMS Fund Act Program 7.27.4 NMAC:

- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
- That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political subdivision.
- That accountability and reporting of these funds shall be in accordance with the requirements set forth by the Local Government Division of the New Mexico Department of Finance and Administration.
- That the funds distributed under the Act will not supplant other funds budgeted and designated for emergency medical service purposes.

*Franklin McCasland*  
Signature of Official Named Above

(Title) *Chairman*

The above was sworn and subscribed to before this *8<sup>th</sup>* day of *January*, 20*19*.

Notary Public:

*Al P. White*

My commission expires:

*3-21-19*



**PERSON COMPLETING FORM**

Name:	Joe A. Garrett <small>(Name)</small>	EMS Coordinator <small>(Title)</small>		
Address:	3298 Quay Road 37			
	Melrose <small>(City)</small>	NM <small>(State)</small>	88124 <small>(Zip)</small>	<small>(+4)</small>
	575-458-9103 <small>(Work Phone)</small>	Forrest 605 <small>(Home Phone #)</small>	575-309-9065 <small>(Cellular Phone #)</small>	Pappyjoe63.jg@gmail.com <small>(E-mail Address)</small>
Signature:	_____			

**FOR BUREAU USE ONLY**

Reviewer: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Approved:      Yes                  No                  Final Award: \_\_\_\_\_

Comments/Problem: \_\_\_\_\_

Date Corrected: \_\_\_\_\_

## Equipment Inventory Report

The following equipment and disposable supplies are required by the Public Regulation Commission and the Medical Rescue Certification regulations. Items that are missing, broken or depleted should be considered as **top priority** items for funding requests. (Please indicate below the number of items "on hand")

### Front of Vehicle Cab or Optimal Location:

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 - 1lb)	4	Siren	1
Flashlight	2	Spare Tire	1
Fuses (appropriate sizes)	10	Star of Life Displayed	4
Jack and Handle	1	Tool Box	1
Lug Wrench	1	Triage Tags for MCI's	2
Maps or Navigational equipment	2	U.S. DOT Emergency Response Guidebook	1
Patient Care Reports or Reporting System	10	Vehicle Registration	1
Roadway warning devices	10	Vehicle Spotlight or auxiliary lighting	1
Service Specific Protocols and guidelines	1	Warning Lights	1
Other: <i>(Specify)</i>			

### Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	2	Spare Batteries/charger system	
EMSCOM (UHF) Radio	1		
Other: <i>(Specify)</i>			

### Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	4 Boxes	Helmet with Face Shield	1
Eye Protection	2	N-95 mask (or > particulate mask)	2 boxes
Gloves (Leather or heavy duty)	2	Safety Vest/Jacket/(ANSI 2008 Compliant)	4
Hearing Protection	1 box	Splash Protection (disposable)	4
Other: <i>(Specify)</i>			

## Diagnostic Equipment

Item Description	On Hand	Item Description	On Hand
Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs	1		
Entitled CO2 monitoring device (optional)	1	Pulse Oximeter	3
Glucose Monitoring Instrument	3	Stethoscope	4
Penlights	4	Thermometer (Patient)	2
Other: (Specify)			

## Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	4	Oxygen Delivery Devices (Adult, Child and Infant Sizes)	12
Auto Ventilator Devices (ATV/MTV)		Oxygen Supply Tubing	
Bag Valve Mask Devices (Adult, Child and Infant)	6	Patient Restraints	1
Band-Aids (Assorted Sizes)	2	Pediatric Drug Dosage Tape or chart	2
Biohazard Clean-up Supplies	2	Pediatric Restraint device/car seat	3
Biohazard Waste bags	2	Pillows	2
Blankets	4	Portable Oxygen Equipment	3
Body Bags	4	Portable Suction Unit	1
Cervical Collars - Rigid (Adult, Child and Infant)	10	Seated Spinal Immobilization Device	2
Cervical Immobilization Devices	10	Semi-Automatic Defibrillator with Pads	
Chair Stretcher	1	Semi-Automatic Defibrillator Batteries	
Cold Pack	10	Sharps Container	2
Cold Weather Warming Devices	10	Sheets	444
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	1	Shoulder/chest/extremity straps	6
Emesis Basin	Box	Spinal Immobilization device/backboard	4
Field Stretcher (Scoop, Collapsible, Vacuum)	1	Splints, Extremity (Rigid, Air, Vacuum)	10
Foil Blanket	2	Sterile Burn Sheets	4
Hand Sanitizer	2	Sterile Gloves (Assorted Sizes)	4
Heat Pack	10	Sterile Water	4
Inhalation Therapy Equipment	1	Stokes Basket	0
Installed Oxygen System	4	Suction Catheters (Soft & Rigid)	4
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	4	Supraglottic Airway Devices	6
Long Backboard	2	Multi-lumen Airway Devices	
Multi-level Stretcher	2	Laryngeal Airway Devices	
Multi-Lumen Airways	1	Towels	
Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2	Traction Splint	
Nasopharyngeal Airways	1	Trauma Dressings	10
Occlusive Dressings	1	Trauma Shears	4
On-Board Suction System	2	Triangular Bandages	10
On-Board Oxygen Supply	2	Urinal (Male and Female)	2
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	2		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for First Responder, EMT-Basic and the Service Medical Director			(Circle) Yes No

Other: <i>(Specify)</i>			
<b>Advance Level</b>			
Alcohol and Betadine Prep Pads	50	IV Fluid (Normal Saline, D5W, LR)	2
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)	2	Laryngoscope Blades – Adult	
Chest Decompression Catheters		Laryngoscope Blades –Peds	
Cricothyroidotomy Kit		Laryngoscope Handle	
EKG Monitor Electrodes	2	Magill Forceps	
Electrode Defib Pads	2	Needles (Assorted Gauges)	
		Pediatric Fluid Control Device	
Endotracheal Tubes (Assorted)		Scalpels	2
Ext. Cardiac Pacing Pads		Syringes (1cc, 3cc, 5cc, 10cc)	12
Infusion Pumps		Toomey Syringe (60cc)	
Inhalation Therapy Equipment		Tubes, Blood Drawing (Assorted Sizes and Types)	4
Intraosseous Needles	12	Tubing, IV Administration (60gts)	3
IV Catheters	4	Tubing, IV Administration Set (10gts – 20gts)	
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Intermediate and EMT- Paramedic, and the Service Medical Director			(Circle) Yes No
Other: <i>(Specify)</i>			

STATE OF NEW MEXICO  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
LOCAL GOVERNMENT DIVISION  
COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM  
GRANT AGREEMENT

Project No. 18-C-RS-I-01-G-02

DUNS # 051336105  
FAIN # B-18-DC-35-001  
CFDA # 14.228  
CDBG FY 18 Award \$11,086,607.00

THIS GRANT AGREEMENT, hereinafter referred to as the "Agreement", is made and entered into by and between the Department of Finance and Administration, State of New Mexico, acting through the Local Government Division, Suite 202, Bataan Memorial Building, Santa Fe, New Mexico, 87501, hereinafter referred to as the "Division", and the Quay County, hereinafter referred to as the "Grantee", as of the date this Agreement is executed by the Division.

**RECITALS**

WHEREAS, on September 19, 2018, the New Mexico Community Development Council ("Council") approved the allocation of Community Development Block Grant ("CDBG") funds to the Grantee for the CDBG program; and

WHEREAS, the CDBG program is subject to all applicable Federal and State laws and regulations, including Title I of the Housing and Community Development Act of 1974, as amended (42 U.S.C. 5301 *et seq.*), and regulations of the U.S. Department of Housing and Urban Development ("HUD") found at 24 CFR Part 570 (as now in effect and as may be amended from time to time); and

WHEREAS, this Agreement is made by and between the Division and the Grantee, in connection with the Division's administration of the CDBG program, and pursuant to the authority of 42 U.S.C. 5301 *et seq.* and 24 CFR Part 570, to memorialize the terms and conditions of the CDBG program and the grant of funds to the Grantee.

**AGREEMENT**

NOW, THEREFORE, in consideration of the mutual covenants and obligations contained herein, and other good and valuable consideration, the receipt of which is hereby acknowledged, the parties agree as follows:

ARTICLE I - SCOPE OF WORK.

- A. The Grantee shall implement, in all respects, the Project Description, attached as Exhibit "1-A", and the Project Schedule, attached as Exhibit "1-B", both of which are incorporated by this reference as if set forth fully herein.
- B. The Grantee shall provide all the necessary qualified personnel, materials, and facilities to implement the program described herein.
- C. The Grantee will adhere to all processes set forth in the CDBG Implementation Manual, which is available at the Division's website at:  
[http://www.nmdfa.state.nm.us/CDBG\\_Implementation\\_Manual.aspx](http://www.nmdfa.state.nm.us/CDBG_Implementation_Manual.aspx) ("CDBG Manual").

ARTICLE II - LENGTH OF GRANT AGREEMENT.

- A. The term of this Agreement shall be effective upon execution by the Division. It shall terminate on the date which is two years after the effective date of this Agreement, which is the Division Director's dated signature, unless earlier terminated pursuant to Article V.
- B. In the event that, due to unusual circumstances, it becomes apparent that this Agreement cannot be brought to full completion within the time period set forth in paragraph A of this Article II, the Grantee may request an extension. Agreement extensions will be approved on a case by case basis and must be requested prior to the termination date set forth in paragraph A of this Article II. The Division may review the work accomplished to date and determine, in its sole discretion, whether there is sufficient need or justification to amend this Agreement to provide additional time for project completion.

ARTICLE III - REPORTS AND PROJECT CLOSEOUT.

- A. Progress Reports:
  - 1. To enable the Division to adequately evaluate the progress of the Agreement, the Grantee shall submit progress reports to the Division on a quarterly basis, with the due dates to be established by the Division. The progress reports shall be submitted on the form attached as exhibit "1-D" and shall contain a description of the work accomplished to date, the methods and procedures used, a detailed budget breakdown of expenditures to date, a statement of the impact of the project, and such other information as the Division may require.
  - 2. One copy of each progress report shall be submitted to the Division. Progress reports shall be due no later than 20 days after the end of each quarter during the term of this Agreement.
  - 3. The Division may require revisions or additional information to clarify progress reports.

- B. Final Report: The Grantee shall submit to the Division one copy of its Final Report, attached as exhibit "1-D-1", with its final Request for Payment, attached as exhibit "1-M", once the Division has determined that the project is complete. The Final Report shall include all of the information required for the progress reports as set forth in paragraph A of this Article III.
- C. Requests for Additional Information: At any time during the term of this Agreement and during the period of time during which Grantee must maintain records pursuant to Article VII, the Division, HUD or the New Mexico State Auditor may (i) request such additional documentation and information regarding Grantee's activities under this Agreement as they deem necessary to discharge their monitoring and compliance responsibilities, and (ii) conduct, at reasonable times and upon reasonable notice, onsite inspections of work performed as well as Grantee's financial and other records concerning the CDBG program. Grantee shall respond to such requests for additional information within a reasonable period of time, as established by the Division (or other entity making the request) in the request. Requests made pursuant to this paragraph D are in addition to and not in lieu of the progress and final reporting described in paragraphs A through C of this Article III.
- D. Project Closeout: Project closeout will occur upon "substantial completion" of the Project. "Substantial Completion" is defined as all five of the following being accomplished, as determined by the Division in its sole discretion: 1) full and satisfactory completion of all work and services; 2) submission to the Division of the Grantee's architect/engineer's letter of final acceptance or certificate of substantial completion relating to the project ("Certificate of Completion") with all deficiencies corrected; 3) official acceptance by the Grantee of all contracted work or services; 4) receipt and approval by the Division of the final reporting referred to in paragraphs B and C of this Article III; 5) clearance by the Division of all monitoring findings; and 6) completion of all the checklists and documents as set forth in chapter 5 of the CDBG Manual. Reimbursements can be withheld from the Grantee until the Division has determined substantial completion has been achieved.

#### ARTICLE IV - GRANT AMOUNT AND METHOD OF PAYMENT.

- A. Amount of Grant: In consideration of the Grantee's satisfactory completion of all work and services required to be performed under the terms of this Agreement, and in compliance with all other Agreement requirements herein stated, the Division shall pay to the Grantee a sum not to exceed Seven Hundred Fifty Thousand Dollars and No Cents (\$750,000.00). The funds are to be expended in accordance with the budget attached as Exhibit "1-C", which is incorporated by this reference as if set forth fully herein, and in accordance with the purposes designated in Exhibit "1-A". Grantee's expenditure of these monies shall not deviate from the line items of said budget without the parties executing an amendment in accordance with Article V.
- B. Amount of Administrative Costs: No more than three percent of the Grant funds actually disbursed pursuant to this Agreement for allowable expenditures may be used by the Grantee for its actual and reasonable administrative costs. The maximum amount of administrative costs under this Agreement shall not exceed Twenty Two Thousand Five Hundred Dollars and No Cents (\$22,500.00).

- C. The funds described in paragraph A above shall constitute full and complete payment of monies to be received by the Grantee from the Division.
- D. All payments to Grantee will be made by the Division upon receipt of an official Request for Payment form, which must be accompanied by a transmittal letter and proper supporting documentation for all expenditures included in the Request for Payment. Requests for Payment may be disputed and withheld if, in the sole opinion of the Division, the Grantee has failed to fulfill its responsibilities under this Agreement. In cases of disputed Requests for Payment, the Grantee agrees that it alone is responsible to timely pay its contractors in compliance with the provisions of the Prompt Payment Act, NMSA 1978, Sections 57-28-1 *et seq.* ("Prompt Payment Act") and the agreements between the Grantee and such contractors.
- E. The Grantee will provide payment to contractors based upon eligible activities as described in exhibit "1-C". The Grantee understands and agrees that it alone is obligated to pay its contractor(s) in a timely manner consistent with the requirements of the Prompt Payment Act. The Grantee further understands and agrees that its obligation is independent of the Division's disbursement of Grant funds and that the Division is in no way responsible to make timely payments to contractors. The Grantee further understands and agrees that it will be responsible for any penalties or fines imposed upon the Division or attorney's fees incurred by the Division due to the Grantee's failure to comply with any provisions of the Prompt Payment Act.
- F. The Grantee further agrees, in compliance with NMSA 1978, Section 57-28-5(B) of the Prompt Payment Act, that the agreement between the Grantee and any contractor shall: 1) specifically provide in a clear and conspicuous manner for a payment within 45 days after submission of an undisputed request for payment; and 2) require the following legend to appear in clear and conspicuous type on each page of the plans including the bid plans and construction plans: "Notice of Extended Payment Provision: This contract allows the owner (Grantee) to make payment within 45 days after submission of an undisputed request for payment".
- G. The Grantee further agrees, in compliance with NMSA 1978, Section 57-28-5(C) of the Prompt Payment Act, that all construction contracts shall provide that contractors and subcontractors make prompt payment to their subcontractors and suppliers for amounts owed for work performed on the construction project within seven days after receipt of payment from the owner, contractor or subcontractor. If the contractor or subcontractor fails to pay its subcontractor and suppliers by first-class mail or hand delivery within seven days of receipt of payment, the contractor or subcontractor shall pay interest to its subcontractors and suppliers beginning on the eighth (8<sup>th</sup>) day after payment was due, computed at one and one-half percent of the undisputed amount per month or fraction of a month until payment is issued. These payment provisions apply to all tiers of contractors, subcontractors and suppliers.
- H. Pursuant to NMSA 1978, Section 57-28-8 of the Prompt Payment Act, ten days after the Certification of Completion is issued, (as defined in paragraph D of Article III), any amounts remaining due the contractor or subcontractor under the terms of the contract shall be paid upon the presentation of the following:
1. A properly executed release and duly certified voucher for payment;

2. A release, if required, of all claims and claims of lien against the owner arising under and by virtue of the contract other than such claims of the contractor, if any, as may be specifically excepted by the contractor or subcontractor from the operation of the release in stated amounts to be set forth in the release; and
  3. Proof of completion.
- I. All CDBG expenditures shall be included in the Grantee's single audit for each fiscal year in which \$750,000 or more in federal funds are expended. Grantees are required to have an audit performed in accordance with Code of Federal Regulations Title 2, Subtitle A, Chapter II, Part 200, Subpart F (Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards—Audit Requirements), which begins at 2 CFR, Section 200.500. Grantees must submit the audit to the Division within 30 days of the date the audit is approved by the New Mexico State Auditor. The threshold of \$750,000 is effective in fiscal years beginning on or after December 26, 2014. CDBG must be listed in the Schedule of Expenditures of Federal Awards (SEFA) as a funding source. The Division retains the right to recover funds from the Grantee for any disallowed costs based on the results of any interim or the final audit.
  - J. Requests for Paid Expenditures: If the Grantee is requesting reimbursement of expenditures it has already paid, and before the Division reimburses the Grantee for the expenditures, the Grantee's authorized signatory shall certify by signing and dating the Request for Payment form, which states that the expenditures are valid, and have been paid by the Grantee. In addition, actual receipts for the expenditures shall be appended to the Request for Payment form, which support the expenditures for which reimbursement is requested. Only expenditures for which there are actual receipts will be reimbursed by the Division.
  - K. Requests for Unpaid Expenditures: If the Grantee is requesting payment of expenditures it has incurred but not yet paid, the Grantee must request and receive written approval from the Division to utilize this payment method. Once approved, the Grantee shall pay such expenditures within three business days of receipt of funds from the Division. The Grantee's authorized signatory shall certify by signing and dating the Request for Payment form, which states that the expenditures are valid. The Grantee shall submit with the request for payment form, the appropriate bank statements, deposit slips and cancelled checks documenting the receipt and disbursement of funds.
  - L. Deficient Requests for Payment: The Division may disallow a Request for Payment, in whole or in part, in the event the Request for Payment is deficient. Examples of deficient Requests for Payment include the lack of required signatures, lack of required supporting documentation, computational errors, seeking reimbursement for unallowable costs, or questions concerning whether the reported expenditures are permissible under this Agreement and applicable law and regulations. If a Request for Payment is disallowed, in whole or in part, the Division shall return to the Grantee the disallowed Request for Payment and accompanying documentation, and will notify the Grantee in writing of the nature of the deficiency and what the Grantee must do to correct it.
  - M. Withholding Payment for Proper Expenditures: The Division shall withhold ten percent of the total amount of the Grant funds until project closeout. The Division may also withhold payment in the event the Grantee has failed to comply with the terms and conditions of this Agreement or

applicable law and regulations. In such event, the Division shall give Grantee notice in writing of such failure and the actions Grantee must take to come into compliance. Payment shall be released upon Grantee's subsequent compliance.

- N. All Requests for Payment shall be received by the Division within 30 days after the Agreement's termination date. The Division reserves the right to allow an extension to this requirement provided there are mitigating circumstances deemed acceptable to the Division. Any reimbursements made to Grantee for items or services that are unallowable under the terms of this Agreement or applicable law and regulations shall be immediately returned to the Division. If any unexpended funds remain after the conditions of this Agreement have been satisfied or after the termination date, the unexpended funds shall revert to the Division for disposition by the Council.

#### ARTICLE V - SUSPENSION, TERMINATION AND MODIFICATION.

- A. In accordance with 24 CFR 85.43, the Division, by written notice to the Grantee, shall have the right to suspend or terminate this Agreement if, at any time, in the judgment of the Division, the Grantee materially fails to comply with any term of this Agreement. The Division may demand repayment of all or part of the funds disbursed to the Grantee upon termination due to non-compliance.
- B. The Agreement may be terminated for convenience in accordance with 24 CFR 85.44.
- C. The terms and conditions of this Agreement can only be modified or changed by written amendment, executed by both the Division and Grantee. Any attempted oral modification of the terms and conditions of this Agreement shall be null and void and of no force or effect.

#### ARTICLE VI - COPYRIGHT AND PATENTS.

No report, map, or other document provided, in whole or in part, under this Agreement, shall be the subject of an application for copyright or patented by or on behalf of the Grantee.

#### ARTICLE VII - RETENTION OF RECORDS.

The Grantee shall keep such records as will fully disclose the amount and disposition of the total funds from all sources budgeted for the Agreement period, the purpose of undertaking for which such funds were used, the amount and nature of all contributions from other sources, all records required to be maintained under Federal law and regulations, and such other records as the Division may prescribe. The Grantee shall be strictly accountable for all receipts and disbursements under this Agreement and maintain fiscal records related to the Agreement in accordance with generally accepted accounting principles. The Grantee shall make all relevant financial and other program records available to the Division, HUD, and the New Mexico State Auditor upon request and shall maintain all such records for a period of not less than six years following project closeout.

ARTICLE VIII - REPRESENTATIVES; NOTICE.

- A. The Grantee hereby designates the person listed below as the official Grantee Representative responsible for overall supervision of the approved project:

Name: Darla Munsell  
Title: Grant Administrator  
Address: PO Box 1246  
Tucumcari, NM 88401  
Telephone: (575) 461-3577  
E-mail: Darla.Munsell@QUAYCOUNTY-NM.GOV

Grantee may change the Grantee Representative by giving the Division written notice of such change, in accordance with paragraph C of this Article VIII.

- B. The Division hereby designates the person listed below as the official Project Manager responsible for overall administration of this Agreement, including compliance and monitoring of Grantee:

Name: Donna Stewart  
Title: Project Manager  
Address: Suite 202, Bataan Memorial Building, Santa Fe, New Mexico 87501  
Telephone: (505) 827-4972  
E-mail: DonnaJ.Stewart@state.nm.us

The Project Manager is the Division representative with the authority to approve on behalf of the Division all matters requiring Division approval under this Agreement. The Division may change the Project Manager by giving Grantee written notice of such change, in accordance with paragraph C of this Article VIII.

- C. Notices of suspension, termination, or any other matter under this Agreement shall be sent by e-mail, or regular mail addressed to the individual designated in or in accordance with paragraphs A and B of this Article VIII. In the case of notices sent by regular mail only, notices shall be deemed to have been given/received upon the date of the party's actual receipt or five calendar days after mailing, whichever shall first occur. A notice sent by e-mail only shall be deemed to have been given/received upon the date of the party's actual receipt.

ARTICLE IX - TERMS AND CONDITIONS.

Except to the extent HUD waives any Federal requirement or regulation, the Grantee shall abide by all applicable Federal and State laws, regulations and rules, policies, guidelines, and requirements with respect to the acceptance and use of Federal CDBG funds for this project, including but not limited to the following:

- A. Title I of the Housing and Community Development Act of 1974, as amended (42 U.S.C. 5301 *et seq.*).

- B. The HUD regulations at 24 CFR Part 570 (as now in effect and as may be amended from time to time).
- C. Construction Project Requirements:
1. The funding assistance authorized hereunder shall not be obligated or utilized for any construction activities until the Grantee has submitted to the Division a Request for Release of Funds and the Division has issued to the Grantee the Authority to Use Grant Funds. The stated forms are included in the CDBG Manual.
  2. The Grantee shall be responsible for assuring the Division that all plans and specifications and related addenda for construction projects comply with the Prompt Payment Act, and have been filed, reviewed and approved for adequacy and code and standards compliances by appropriate State agencies as may be required before a project is advertised for sealed construction bids. Evidence of any such filing, review and compliance shall be provided to the Division prior to bid advertisement. All subsequent change orders must be submitted to the Division for review and approval prior to execution.
  3. Assistance from the State of New Mexico, Community Development Council, shall be acknowledged by project signs erected at the project site prior to and maintained during construction. Project signs shall include the "New Mexico Department of Finance and Administration" as the funding agency, the Governor's name, the Community Development Council members names, the name of the project's architect/engineer, the name of the project, the name of the Grantee, total cost of the project, and a listing of other financial participation by dollar amount from all sources. Project signs shall be weatherproof and shall be painted on one side with a background color of yellow with red lettering of  $\frac{3}{8}$ " thick, not smaller than 4' x 6' nor larger than 4' x 8', marine-grade plywood. Each sign shall be mounted on two 4" x 4" posts, with the bottom of the sign at least four feet above grade. The sign shall be mounted level at the location designated by the Grantee. The Grantee shall remove the sign upon completion of the construction project.
  4. Acknowledgment of funding assistance from the CDBG Program shall be included on any permanent signs, plaques or other displays at facilities constructed with grant assistance.
- D. Reversion of Assets: The Grantee agrees that upon the expiration of this Agreement, the Grantee shall transfer to the Division any funds on hand at the time of the expiration and any accounts receivable attributable to the use of CDBG funds. The Grantee agrees that, upon expiration, any real property under the Grantee's control that was acquired or improved, in whole or in part, with CDBG funds (including in the form of a loan) in excess of \$25,000, shall continue to either: 1) be used to meet one of the national objectives in the Criteria for National Objectives, set forth at 24 CFR 570.208, until five years after expiration of the Agreement, or for such longer period of time as determined to be appropriate by the Division; or 2) if not used in accordance with 24 CFR 570.208, then the Grantee shall, at the time of the change in use, pay the Division an amount equal to the current market value of the property less any portion of the value attributable to expenditures of non-CDBG funds for the acquisition of, or improvement to, the property. The payment is program income to the Division. No payment is required after five years after expiration of this Agreement,

or for such longer period as determined to be approved by the Division.

- E. Program Income: The Grantee shall comply with the program income requirements set forth at 24 CFR 570.504(c). In addition, at the end of the program year, the Division may require remittance of all or part of any program income balances (including investments thereof) held by the Grantee (except those needed for immediate cash needs, cash balances of a revolving loan fund, cash balances from a lump sum drawdown, or cash or investments held for Section 108 security needs).
- F. Uniform Administrative Requirements: The Grantee shall comply with applicable uniform administrative requirements, as described in 24 CFR 570.502.
- G. Other Program Requirements:
1. The Grantee shall carry out each activity in compliance with all Federal laws and regulations described in subpart K of the HUD regulations (found at 24 CFR 570.600 – 614, as may be amended from time to time), including, but not limited to, regulations relating to:
    - (a) Public Law 88-352 and Public Law 90-284; affirmatively furthering fair housing; Executive Order 11063 (§570.601);
    - (b) Section 109 of the Act (prohibiting discrimination)(§570.602);
    - (c) Labor standards (§570.603);
    - (d) Environmental standards (§570.604);
    - (e) National Flood Insurance Program (§570.605);
    - (f) Displacement, relocation, acquisition, and replacement of housing (§570.606);
    - (g) Employment and contracting opportunities (§570.607);
    - (h) Lead-based paint (§570.608);
    - (i) Use of debarred, suspended, or ineligible contractors or sub-recipients (§570.609);
    - (j) Uniform administrative requirements and cost principles (referencing OMB Super Circular Uniform Guidance 2 CFR Part 200)(§570.610);
    - (k) Conflict of interest (§570.611);
    - (l) Executive Order 12372 (relating to water or sewer facility projects)(§570.612);
    - (m) Eligibility restrictions for certain resident aliens (§570.613); and
    - (n) Architectural Barriers Act and the Americans with Disabilities Act (§570.614).
  2. Notwithstanding any provision in Section G(1) of this Article IX to the contrary:
    - (a) The Grantee does not assume the Division's environmental responsibilities described in 24 CFR 570.604; and
    - (b) The Grantee does not assume the Division's responsibility for initiating the review process under the provisions of 24 CFR Part 52.
- H. Conflict of Interest: The Grantee shall comply with the conflict of interest provision set forth in 24 CFR 85.36 of the HUD regulations. No officer or employee of the local jurisdiction or its designees or agents, no member of the governing body, and no other public official of the locality who exercises any function or responsibility with respect to this Agreement, during his/her tenure or for one year thereafter, shall have any interest, direct or indirect, in any contract or subcontract, or the proceeds

thereof, for work to be performed under this Agreement. Further, the contractor shall cause to be incorporated in all of its subcontracts for work funded under this Agreement the language set forth in this paragraph prohibiting conflicts of interest.

- I. Hatch Act: The Grantee shall comply with the provisions of the Hatch Act, which limits the political activity of employees.
- J. Federal Reporting: The Grantee shall comply with requirements established by the Office of Management and Budget (OMB) concerning the Dun and Bradstreet Data Universal Numbering System (DUNS), the System for Award management (SAM) database, and the Federal Funding Accountability and Transparency Act, including Appendix A to Part 25 of the *Financial Assistance Use of Universal Identifier and Central Contractor Registration*, 75 Fed. Reg. 55671 (Sept. 14, 2010) (to be codified at 2 CFR Part 25) and Appendix A to Part 170 of the *Requirements for Federal Funding Accountability and Transparency Act Implementation*, 75 Fed. Reg. 55663 (Sept. 14, 2010) (to be codified at 2 CFR Part 170).
- K. Procurement: The Grantee shall comply with the HUD Procurement (24 CFR Part 85.36), New Mexico State Procurement Code, NMSA 1978, Sections 13-1-28 through 13-1-199 , and the purchasing regulations of the New Mexico General Services Department, State Purchasing Division.
- L. Compliance with New Mexico Administrative Code Rule: The Grantee shall comply with Rule 2.110.2 NMAC.
- M. Costs: The Grantee shall finance its share of the costs of the project, including all project overruns.
- N. Prior Approval: The Grantee shall submit all project-related contracts, subcontracts, agreements and subsequent amendments, funded in whole or in part with CDBG funds, to the Division for review and approval prior to execution. Disbursement of Grant funds is conditioned upon the Grantee's contracts, subcontracts and agreements complying with the requirements of Article IV of this Agreement. The Grantee shall provide the Division with any other project-related contracts, and agreements upon the Division's request.
- O. Compliance and Waivers: Except to the extent that the Division waives in writing any requirement contained therein, the Grantee shall abide by, and this Agreement incorporates all applicable provisions of, the Division's CDBG Manual, as it may be amended from time to time.

#### ARTICLE X - CERTIFICATIONS.

By signing this Agreement, the Grantee certifies the following requirements:

- A. Anti-Lobbying: To the best of the Grantee's knowledge and belief, the Grantee certifies that:
  - 1. No Federal appropriated funds have been paid or will be paid, by or on behalf of it, to any person for influencing or attempting to influence an officer or employee or any agency, a Member of Congress, an officer or employee of Congress, or any employee of a Member of

Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement;

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, it will complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions; and
  3. It will require that the language of paragraphs A(1) and (2) of this Article X be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.
- B. Local Needs Identification: The Grantee certifies that it has identified its community development and housing needs, including the needs of low-income and moderate-income families, and the activities to be undertaken to meet these needs.
- C. Special Assessments: The Grantee certifies that:
1. It will not attempt to recover any capital costs of public improvements assisted with CDBG funds including Section 108 loan guaranteed funds by assessing any amount against properties owned and occupied by persons of low and moderate income, including any fee charged or assessment made as a condition of obtaining access to such public improvements, except that;
  2. An assessment or charge may be made against the property with respect to the public improvements financed by a source other than CDBG funds, if CDBG funds are used to pay the proportion of a fee or assessment that relates to the capital costs of public improvements (assisted in part with CDBG funds) financed from other revenue sources; and
  3. It will not attempt to recover any capital costs of public improvements assisted with CDBG funds, including Section 108, unless CDBG funds are used to pay the proportion of fee or assessment attributable to the capital costs of public improvements financed from other revenue sources. In this case, an assessment or charge may be made against the property with respect to the public improvements financed by a source other than CDBG funds. Also, in the case of properties owned and occupied by moderate-income (not low-income) families, an assessment or charge may be made against the property for public improvements financed by a source other than CDBG funds if the jurisdiction certifies that it lacks CDBG funds to cover the assessment.
- D. Excessive Force: The Grantee certifies that it has adopted and is enforcing the following:
1. A policy prohibiting the use of excessive force by law enforcement agencies within its jurisdiction against any individuals engaged in non-violent civil rights demonstrations; and

2. A policy of enforcing applicable State and local laws against physically barring entrance to or exit from a facility or location, which is the subject of such non-violent civil rights demonstrations within its jurisdiction;
- E. Citizen Participation: The Grantee certifies that it has followed a detailed citizen participation plan that satisfies the requirements of 24 CFR 570.486, and will continue to provide opportunities for citizen participation.
- F. Small Minority and Women's Business Enterprise: The Grantee certifies that it will, to the maximum extent feasible, contract and subcontract with eligible small, minority and women's business enterprises and utilize eligible businesses which are owned by persons located in the unit of local government in which the project is administered.
- G. Section 3: The Grantee certifies that it shall comply with Section 3 of the Housing and Urban Development Act of 1968, and implementing regulations at 24 CFR Part 135.
- H. Overall Benefit: The Grantee certifies that the aggregate use of the Grant funds shall principally benefit persons of low and moderate income in a manner that ensures that at least seventy percent (70%) of the amount is expended for activities that benefit such persons.
- I. Drug Free Workplace: The Grantee certifies that it will or will continue to provide a drug-free workplace by:
1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
  2. Establishing an ongoing drug-free awareness program to inform employees about –
    - (a) The dangers of drug abuse in the workplace;
    - (b) The Grantee's policy of maintaining a drug-free workplace;
    - (c) Any available drug counseling, rehabilitation, and employee assistance programs; and
    - (d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
  3. Making it a requirement that each employee to be engaged in the performance of the Grant be given a copy of the statement required by paragraph I(1) of this Article X;
  4. Notifying the employee in the statement required by paragraph I(1) of this Article X that, as a condition of employment under the Grant, the employee will –
    - (a) Abide by the terms of the statement; and
    - (b) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

5. Notifying the agency in writing, within ten calendar days after receiving notice under paragraph I(4)(b) of this Article X from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
  6. Taking one of the following actions, within thirty calendar days of receiving notice under paragraph I(4)(b) of this Article X, with respect to any employee who is so convicted –
    - (a) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    - (b) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
  7. Make a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs I(1)–(6) above.
- J. Compliance with Anti-discrimination Laws: The Grantee certifies that this Agreement will be conducted and administered in conformity with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), the Fair Housing Act (42 U.S.C. 3601-3619), and implementing regulations.
- K. Compliance with Laws: The Grantee certifies that it shall comply with applicable laws.
- L. Subawards to Debarred and Suspended Parties: The Grantee certifies that it shall comply with 24 CFR 85.35 in that it must not make any award or permit any award (subgrant or contract) at any tier to any party that is debarred or suspended or is otherwise excluded from or ineligible for participation in federal assistance programs subject to 2 CFR part 2424.
- M. Local Needs Identification: The Grantee certifies that it has identified its community development and housing needs, including the needs of low-income and moderate-income families, and the activities to be undertaken to meet these needs.

#### ARTICLE XI - GENERAL ASSURANCES:

The Grantee represents and warrants that:

1. It has the legal authority to receive and expend the Grant funds and execute a CDBG program;
2. This Agreement has been duly authorized by the Grantee's governing body, the person executing this Agreement has authority to do so, and, once executed by the Grantee, this Agreement shall constitute a binding obligation of the Grantee, enforceable according to its terms.

3. This Agreement and the Grantee's obligations under this Agreement do not conflict with any law applicable to the Grantee's charter (if applicable), or any judgment or decree to which it is subject.

ARTICLE XII - ENTIRE AGREEMENT.

This Agreement contains the entire agreement between the Grantee and the Division. There are no promises, agreements, conditions, undertakings, warranties or representations, oral or written, expressed or implied, between them, other than what is herein set forth.

ARTICLE XIII - APPROPRIATIONS.

The Division's performance and liability under this Agreement is contingent upon sufficient authority and appropriations being granted to the Division by HUD and the Council.

ARTICLE XIV - GOVERNING LAW.

This Agreement shall be construed and governed by the substantive laws of the State of New Mexico, without giving effect to its choice of law rules, and applicable Federal laws and regulations.

ARTICLE XV – LIABILITY.

Each party shall be solely responsible for its own liability under this Agreement, subject to the immunities and limitations of the New Mexico Tort Claims Act, NMSA 1978, Sections 41-4-1 *et seq.*

[This space intentionally left blank.]

IN WITNESS WHEREOF, the Grantee and the Division do hereby execute this Agreement as of the date of signature by the Division below.

THIS GRANT AGREEMENT has been approved by:

Quay County

  
Chief Elected Official/Authorized Signatory

1-7-2019

Date

FRANKLIN McCASLAND  
Type or Print Name



DEPARTMENT OF FINANCE AND ADMINISTRATION  
LOCAL GOVERNMENT DIVISION

\_\_\_\_\_  
Division Director

\_\_\_\_\_  
Date

**EXHIBIT 1-A**

**PROJECT DESCRIPTION**

**GRANTEE NAME**      Quay County

**PROJECT NUMBER**    18-C-RS-I-01-G-02

**GRANT AMOUNT**                      \$750,000.00

**PROJECT DESCRIPTION**

Quay County, NM located in Tucumcari will design and construct road and drainage improvements on Quay Road AR at Latitude 35.1722, -103.7728 Longitude and will end approximately 40 feet north of the intersection with Quay Road 64.5 Latitude 35.1939 and Longitude -103.7728

Road and drainage improvements will consist of construction of drainage ditches, the installation of a crossing culvert pipe, reclaiming the existing road surface, LithTec sub-grade treatment, and two courses of double penetration chip seal. An estimated 40 linear feet of culvert pipes will be installed underneath driveways and across the roadway. Approximately 20,267 square yards of roadway will be reclaimed and treated with LithTec sub-grade treatment. An estimated 18,578 square yards of chip seal road surface will be placed over the lithified base.

**NATIONAL OBJECTIVE (from DFA/LGD approved survey)**

This project will benefit 202 total beneficiaries of which 53.46 % are Low and Moderate Income (LMI).

**CASH MATCH and LEVERAGING (from CDBG Application)**

Quay County will provide a 5 % Cash Match of \$ 37,500 in addition to \$ 96,318.84 in leveraging.

EXHIBIT 1-B

PROJECT SCHEDULE

Grantee Name: QUAY COUNTY CDBG Project Number: 18-CRS-1-01-G-02 Project Description: Streets and/or drainage Improvements on Quay Road AR	Project Start Date 12//2018				Project Completion Date 12//2020																				
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter																	
<b>ADMINISTRATION/PROFESSIONAL SERVICES</b> Year: 2018/2019																									
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
1. Create Plans & Adopt Federal Requirements for Procurement, Fair Housing, Anti-Displacement, Section 3, Citizen Participation						X													X						
2. Set Up CDBG Accounting [Authorized Signatories (1-6), Substitute W9 (1-1), Fidelity Bond & Proof Cash Match/Leverage]											XXXX	XXXX													
3. Environmental Review Record (Start Date - Authority to Use Grant Funds)											XXXX	XXXX	XX												
4. Complete RFP for Professional Services and Submit to DFA/LGD											XXXX														
5. DFA/LGD Review/Approval of RFP											XXXX														
6. Conduct Procurement for Professional Services											XXXX														
7. Execute Engineering Agreement and Submit to DFA/LGD											XXXX														
8. DFA/LGD Concurrence of Engineering Contract											XXXX														
<b>PLANNING/DESIGN</b> Year: 2018/2019																									
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
9. Complete Plans, Specs and Bid Documents									XX	XXXX	XX														
10. Submit Plans, Specs and Bid Docs to Subject Matter Expert (SME) Agency/Agencies (NMED, NMDOT, GCD, CID, etc.)																	XXXX	XXXX							
11. Submit Plans, Specs and Bid Docs to DFA/LGD with SME Agency/Agencies Approval(s)																			XXXX	XXXX					
12. DFA/LGD Approval of Plans, Specs and Bid Docs																					XXXX				
13. Collect Bids and Award Construction Contract																						XXXX	XXXX		
14. DFA/LGD Review/Approval of Construction Contract																							XXXX		
<b>CONSTRUCTION/CLOSEOUT</b> Year: 2020																									
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
15. Pre-Construction Conference and Issue Notice to Proceed			XX	XX																					
16. Construction (Start Date - Completion)				XX	XXXX	XXXX	XX																		
17. Final Inspection and Closeout Monitoring Review							XX	XXXX																	
18. Complete Closeout Checklist and Submit Final Reimbursement Request											XXXX														

Entity Name: <u>QUAY COUNTY</u>		<input checked="" type="checkbox"/> Grant Agreement		CDBG Amount: \$ 750,000.00		
CDBG Project Number: _____		<input type="checkbox"/> Grant Amendment		Other Amount: \$ 133,818.84		
Project Cost Activities	Project Funding Sources					Total Project Cost
	CDBG Funds	Other Sources (Identify other local, state, federal, or private)				
		Cash Match	Leverage			
Administration (Contractual)						\$ -
Architect/Engineer	\$ 29,607.19	\$ 37,500.00	\$ 96,318.84			\$ 163,426.03
Other Professional						\$ -
Inspection (Testing)						\$ -
Property Acquisition						\$ -
Property Rehabilitation						\$ -
Construction	\$ 720,392.81					\$ 720,392.81
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
<b>Totals</b>	<b>\$ 750,000.00</b>	<b>\$ 37,500.00</b>	<b>\$ 96,318.84</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 883,818.84</b>

## EXHIBIT 1-D PROGRESS REPORT

Grantee: Quay County Grant Amount: \$ 750,000.00

Project Number: 18-C-RS-I-01-G-02 Reporting Period:

A. The "Scheduled Dates" have been identified based on the Project Schedule (Exhibit 1-B) of the Grant Agreement. Please indicate the tasks accomplished to date as well as the "Actual Date" of completion:

Grant Execution Date: <u>12/20/18</u>	SCHEDULED DATE	ACTUAL DATE
1. Create Plans & Adopt Federal Requirements for Citizen Participation, Procurement, Fair Housing, Anti-Displacement, Section 3	12/30/18	
2. Set Up CDBG Accounting [Authorized Signatories (1-G), Substitute W9 (1-I), Fidelity Bond & Proof Cash Match/Leverage	12/30/18	
3. Environmental Review	1/15/19	
SHPO Approval Granted		
Environmental Assessment Submitted	1/31/19	
Authority to Use Grant Funds Issued	2/28/19	
4. Complete RFP for Professional Services and Submit to DFA/LGD	5/14/18	
5. DFA/LGD Review/Approval of RFP	11/30/18	
6. Conduct Procurement for Professional Services	6/1/18	
7. Execute Engineering Agreement and Submit to DFA/LGD	12/20/18	
8. DFA/LGD Concurrence of Engineering Contract	12/15/18	
9. Complete Plans, Specs and Bid Documents	6/14/19	
10. Submit Plans, Specs and Bid Docs to Subject Matter Expert (SME) Agency/Agencies (NMED, NMDOT, GCD, CID, etc.)	6/18/19	
11. Submit Plans, Specs and Bid Docs to DFA/LGD with SME Agency/Agencies Approval(s)	7/22/19	
12. DFA/LGD Approval of Plans, Specs and Bid Docs	8/5/19	
13. Collect Bids and Award Construction Contract	11/27/19	
14. DFA/LGD Review/Approval of Construction Contract	12/21/19	
15. Pre-Construction Conference and Issue Notice to Proceed	3/30/20	
16. Construction		
Start Date	4/30/20	
% of Construction Work Completed*	%	0%
Construction Complete	7/31/20	
17. Final Inspection and Closeout Monitoring Review	10/1/20	
18. Complete Closeout Checklist and Submit Final Pay Request	10/26/20	

B. If a contract was executed with an Administrative, Professional or Construction service provider during the reporting period, please indicate "Yes" and submit a Contractor/Subcontractor Activity Report (Exhibit 1-E):

	Yes	No	N/A	Date Submitted
Administrative Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100px; height: 20px;" type="text"/>
Professional Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100px; height: 20px;" type="text"/>
Construction (Contractors and Subcontractors)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100px; height: 20px;" type="text"/>

**CDBG Progress Report**

- C. Timely expenditures are a critical aspect of compliance. Grantees are expected to have requested reimbursements no later than 9 months from the date of execution. From the grant execution date, the initial request for reimbursement was received within (if yes, indicate date completed):

Grant Execution Date: 12/20/18	No	Yes	Date Complete
- first 6 months after grant execution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- first 9 months after grant execution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- first 12 months after grant execution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

- D. Describe Tasks/Goals/Milestones accomplished during this quarter (include dates):

- E. Describe any problems encountered or delays experienced in the implementation and administration of the project. Also, discuss actions or methods used or to be used in alleviating the problem. Attach additional sheets if necessary.

- F. Provide a detailed budget breakdown of cash match and/or leveraging expenditures to date on the Cash Match/Leveraging Tracking Sheet (Exhibit 1-J). All supporting documentation for the current quarter must be submitted with a Financial Status Report (Exhibit 1-M). If no financial activity took place, please indicate "No" for parts (a) (b) and "No Financial Activity during this Quarter for part (c):

	Yes	No
(a) Exhibit 1-J attached	<input type="checkbox"/>	<input type="checkbox"/>
(b) Exhibit 1-M attached	<input type="checkbox"/>	<input type="checkbox"/>
(c)	<input type="text" value="&lt;Select Supporting Document Status&gt;"/>	

Certification

Under penalty of law, I hereby certify that to the best of my knowledge and belief that the information contained in this report is correct and true.

\_\_\_\_\_  
Signature of Grantee Representative

\_\_\_\_\_  
Signature of Chief Elected Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**NEW MEXICO COMMUNITY DEVELOPMENT BLOCK GRANT**  
**Request for Payment/Financial Status Report**  
**Exhibit 1-M**

Payment Request Number: \_\_\_\_\_

- I. A. Grantee: \_\_\_\_\_  
 B. Bank Name: \_\_\_\_\_  
 Bank Address: \_\_\_\_\_  
 (Physical & Mailing): \_\_\_\_\_  
 C. Grantee Phone Number: \_\_\_\_\_  
 D. Account No. \_\_\_\_\_  
 E. Routing No. \_\_\_\_\_  
 F. Grant No. \_\_\_\_\_

II. Payment Computation:

A. Grant Award	\$0.00
B. Funds Received to Date	\$0.00
C. Requested this Payment	\$0.00
D. Grant Balance	\$0.00

III. Report Period Ending \_\_\_\_\_

Budget Categories	Approved Budget			Expenditures This Request			Expenditures to Date		
	Grant Funds	Match Funds	Total Budget	Grant Funds	Match Funds	Total Expenditures	Grant Funds	Match Funds	Total Expenditures
Administration (Contractual)			\$0.00			\$0.00			\$0.00
Architect/Engineer			\$0.00			\$0.00			\$0.00
Other Professional			\$0.00			\$0.00			\$0.00
Inspection (Testing)			\$0.00			\$0.00			\$0.00
Property Acquisition			\$0.00			\$0.00			\$0.00
Property Rehabilitation			\$0.00			\$0.00			\$0.00
Construction			\$0.00			\$0.00			\$0.00
<b>TOTALS:</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

IV. CERTIFICATION: Under penalty of law, I hereby certify that to the best of my knowledge and belief, the above information is correct, expenditures are properly documented, required matching funds have been spent/obligated in the reported amount, and that copies of all required documentation attached for this payment request are true and correct copies of the originals.

Authorized Signatory \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signatory \_\_\_\_\_ Date \_\_\_\_\_

Print or Type Name \_\_\_\_\_

Print or Type Name \_\_\_\_\_

- \* Both local level signatures must match depository/signature card.
- \*\* Authorizing official is not authorized to sign Request for Payment/Financial Status Report.

(DFA Local Government Division Use Only)

Division Fiscal Officer \_\_\_\_\_ Date \_\_\_\_\_

Division Project Representative \_\_\_\_\_ Date \_\_\_\_\_

# EXHIBIT 1-D-1 FINAL REPORT

**CDBG Final Report**

1. List other public/private funds used in conjunction with this project:

Public \_\_\_\_\_ Private \_\_\_\_\_ In-Kind \_\_\_\_\_

2. State/national objectives the project addresses: <Select National Objective>

If project addresses multiple objectives explain:

3. Indicate Project Impact by providing the following information, if applicable:

	Projected	Actual
Number of Housing Units Rehabilitated	_____	_____
Number of Jobs Created	_____	_____
Number of Jobs Retained	_____	_____
Number of Persons Served by Community Facilities	_____	_____

a. Type of Facility \_\_\_\_\_

b. Number of Facilities \_\_\_\_\_

4. a. Provide the total number of direct beneficiaries of this project:

Projected # \_\_\_\_\_ Actual # \_\_\_\_\_

Projected Minorities (if available) # \_\_\_\_\_ Actual Minorities (if available) # \_\_\_\_\_

b. Indicate the number of low/moderate income persons benefiting from this project:

Total LMI beneficiaries = \_\_\_\_\_

Total Minority LMI beneficiaries (if available) = \_\_\_\_\_

c. Indicate the percentage of low/moderate income persons benefiting from this project:

(total # LMI beneficiaries / actual # beneficiaries) = 0.00%

[(total # minority beneficiaries / actual # beneficiaries), if available] = 0.00%

d. Indicate the dollar amount of funds directly benefiting low/moderate income persons:

(total amount of CDBG funding X percentage of LMI beneficiaries) = \$ \_\_\_\_\_

[(total amount of CDBG funding X percentage of minority LMI beneficiaries), if available] =

\$ \_\_\_\_\_

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4. e. Total number of direct beneficiaries:

1. Ethnicity:

- (a) Hispanic or Latino # \_\_\_\_\_
- (b) Not Hispanic or Latino # \_\_\_\_\_

2. Race:

- (a) American Indian or Alaskan Native # \_\_\_\_\_
- (b) Asian # \_\_\_\_\_
- (c) Black or African American # \_\_\_\_\_
- (d) Native Hawaiian or  
Other Pacific Islander # \_\_\_\_\_
- (e) White # \_\_\_\_\_
- (f) American Indian or  
Alaska Native *and* White # \_\_\_\_\_
- (g) Asian *and* White # \_\_\_\_\_
- (h) Black or African American  
*And* White # \_\_\_\_\_
- (i) American Indian or Alaska Native  
*And* Black or African American # \_\_\_\_\_

3. Gender:

- (a) Male # \_\_\_\_\_
- (b) Female # \_\_\_\_\_
- (c) Female-Head of Household # \_\_\_\_\_

5. Indicate the amount of CDBG money used in the following categories.

	Projected	Completed
Community Infrastructure	_____	_____
Housing Rehabilitation	_____	_____
Public Service Capital Outlay	_____	_____
Economic Development	_____	_____
Administration (Planning Technical Assistance)	_____	_____

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6. Based on the applicable national objective(s) identified in question #2, how did this project meet this requirement? Describe the need and impact of this project on the community as a whole and specifically on the LMI beneficiaries. Attach additional sheets if necessary.

7. Did any wage and/or overtime violations occur at any time during the grant?

Yes

No (skip to #8)

1. If "Yes", have all documents pertaining to wage/overtime violations been submitted to DFA/LGD?

- Final Wage Compliance Report (Exhibit 4-R)

- Employee Restitution Receipt(s) (Exhibit 4-R-1)

- Federal and State Wage Violation Tracking Sheet (Exhibit 4-R-2)

- UPDATED Contractor and Subcontractor Activity Form (Exhibit 1-E)

- Overtime Violation Report (Exhibit 4-Q) [if applicable]

8. Grant Monitoring

Was an annual monitoring conducted by DFA/LGD for this project?  Yes  N/A

Was a closeout monitoring conducted by DFA/LGD for this project?  Yes  No

Certification

Under penalty of law, I hereby certify that to the best of my knowledge and belief that the information contained in this report is correct and true.

\_\_\_\_\_  
Signature of Grantee Representative

\_\_\_\_\_  
Signature of Chief Elected Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

DATE/18	NAME	ROAD BLADED	BLOCKS	MILES	ADDITIONAL WORK TO ROAD/COMMENTS
12/03/18	DONALD	QUAY ROAD 31	4300-4500	2.00	
	DONALD	QUAY ROAD AT	3000-3200	2.00	
	DONALD	QUAY ROAD AS	3100-3200	1.00	
	ARMANDO	QUAY ROAD AJ	7150-7250	0.84	
	ARMANDO	QUAY ROAD AI	7200-7375	1.75	
	ARMANDO	QUAY ROAD 72	3375-3500	1.25	
	ARMANDO	QUAY ROAD 71	3300-3400	1.00	
	LOUIS	QUAY ROAD 64	1900-2100	2.00	
12/04/18	LOUIS	QUAY ROAD 65	1800-2000	2.00	
	LOUIS	QUAY ROAD Q	6500-6600	1.00	
	DONALD	QUAY ROAD 32	4400-4600	2.00	
	DONALD	QUAY ROAD AS	3200-3300	1.00	
	DONALD	QUAY ROAD AT	2700-3000	3.00	
	ARMANDO	QUAY ROAD AG	6850-6900	0.50	
	ARMANDO	QUAY ROAD AF	6850-6925	0.44	
	ARMANDO	QUAY ROAD 69	3100-3400	3.00	
	ARMANDO	QUAY ROAD AF.5	6900-6970	0.70	
12/05/18	LOUIS	QUAY ROAD P	6500-6600	1.45	
	LOUIS	QUAY ROAD O	6600-6775	1.45	
	ARMANDO	QUAY ROAD AE	6600-6900	3.00	
	ARMANDO	QUAY ROAD 67	2800-3150	3.50	
	ARMANDO	QUAY ROAD 70	3300-3400	1.00	
	ARMANDO	QUAY ROAD AH	7000-7100	1.00	
12/06/18	LOUIS	QUAY ROAD 58	2200-260	4.00	
	LOUIS	QUAY ROAD U	5800-5950	1.50	
12/10/18	LOUIS	RT. 66	0500-0700	6.50	
	ARMANDO	QUAY ROAD 43	1900-2100	3.00	
	DONALD	QUAY ROAD AS	3100-3300	2.00	
	DONALD	QUAY ROAD AV	3100-3200	1.00	
12/11/18	LOUIS	QUAY ROAD E	6600-7350	7.40	
	LOUIS	QUAY ROAD 66	0300-0500	2.00	
	DONALD	QUAY ROAD 31	4700-4800	1.00	
	DONALD	QUAY ROAD AW	3000-3250	2.50	
	DONALD	QUAY ROAD AS	3400-3600	2.00	
	ARMANDO	QUAY ROAD 49	2000-2200	2.00	
	ARMANDO	QUAY ROAD 47	1700-1900	2.00	
	ARMANDO	QUAY ROAD Q	4600-4700	1.00	
12/12/18	LOUIS	QUAY ROAD C	6600-6750	1.50	
	LOUIS	RT. 66	0700-1100	4.00	
	LOUIS	QUAY ROAD G	5900-6600	1.00	
12/13/18	LOUIS	QUAY ROAD F	5950-6050	1.00	
	LOUIS	QUAY ROAD 60	0875-1000	1.40	
	LOUIS	QUAY ROAD 57	1800-2200	4.00	
12/17/18	DONALD	QUAY ROAD 24	5000-5200	2.00	
	LOUIS	QUAY ROAD V	5550-5700	1.50	
	LOUIS	QUAY ROAD 55	1800-2200	4.57	

12/18/18	DONALD	QUAY ROAD 24	5000-5400	4.00
	LOUIS	QUAY ROAD U	5700-5800	1.00
	LOUIS	QUAY ROAD 58	2100-2200	1.00
	LOUIS	QUAY ROAD S	5700-5875	1.55
	LOUIS	QUAY ROAD 54	1750-1800	0.50
12/27/18	LOUIS	QUAY ROAD 66	1800-2000	2.00
	LOUIS	QUAY ROAD T	6600-6700	1.00
		<b>TOTAL</b>		<b>106.80</b>