Nebraska EMS Conference Grant Guidelines

Application for Conference Tuition Funds should be submitted a minimum of 30 days in advance of the conference.

The Nebraska Office of Emergency Health Systems (EHS) may fund conferences for Emergency Medical Services Providers based on available continuing education funds.

Please note the following requirements:

1. The Nebraska Office of Emergency Health Systems funds must be used to offset tuition (registration fees). Funds are not to be used for profit.
2. The Nebraska Office of Emergency Health Systems must be identified as a participant in funding on all advertising, brochures, and conference materials.
3. Request funding for one conference per form.
4. Conference Applications should be submitted no later than **30 days in advance of the conference** to ensure time for approval and advertisement. Applications will be accepted less than 30 days before the conference but the Office of EHS reserves the right to deny approval. The Office of Emergency Health System reserves the right to refuse applications.
5. A copy of the brochure **MUST** also be submitted with the application.
6. The invoice and roster (sample provided) **MUST** be returned to the EHS office within **30 days** of completion of the conference. Failure to comply may result in nonpayment.
7. A conference is defined as having two or more instructors, offering at least six (6) hours of continuing education, and having multiple EMS topics.
8. Classes must meet the objectives of the National EMS Education Standards for the EMR, EMT, Advanced EMT, and/or Paramedic.
9. Grant funds may not be used for certifying courses (EMR, EMT, AEMT, Paramedic), additional skill modules, nor can they be used for refresher courses.
10. Funds may be used for EMS-Instructor development topics that fit into one of the four required instructor renewal subject renewal areas.
11. A qualified EMS Instructor or subject matter expert in a specific field must teach all classes.
12. The conference will be reimbursed registration tuition cost based on the number of **Nebraska licensed EMS provider** in attendance. Conference attendance break down:
    - Over 300 - $50.00 per attendee
    - 200 – 299 - $40.00 per attendee
    - 100 – 199 - $30.00 per attendee
    - Less than 100 - $20.00 per attendee
    - If conference attendance is lower than the estimated number submitted, the corresponding tiered amount will be reimbursed.
13. Final total reimbursement request not to exceed approved amount.
14. Attendees that are not a Nebraska licensed EMS provider are not eligible for reimbursement.
15. The applicant must provide the following items in order to receive reimbursement for approved conference:
    - Signed invoice (On Conference Funding Request form)
    - Conference roster & conference brochure
16. Classes must be open to all EMS Providers.
17. It is the responsibility of the applicant to advertise for the conference.
18. W9 & ACH Form is attached.
19. If a sign in roster is attached.

Send completed form and required documentation to
dhhs.sp.EHSContinuingED@nebraska.gov

Direct questions to Wendy Snodgrass: 402-873-5082 or wendy.snodgrass@nebraska.gov

Revised 2/1/19

Grant Funds Application Form/Invoice for Reimbursement

Emergency Medical Services Conference Funding Request

Recommended to be submitted at least 30 days before the conference.
Please fill out electronically.

Applicant Information		
Applicant Name:		
Contact Name:		
Contact Daytime Phone:		
Contact Evening Phone:		
Contact Email:		
Conference Information		
Conference Title:		
Conference Objective:		
Start Date and Time:	**Date:**	**Time:**
End Date and Time:	**Date:**	**Time:**
Total Contact Hours:		
Place/Location of Conference:		
Address of Conference:		
City/Town of Conference:		
County of Conference:		

Requested Budget Information	
Estimated Total Projected Conference Expenses	**$**
Estimated Registration Revenue	**$**
Estimated Sponsor/Grant Revenue	**$**
Scholarships	**$**
Conference Registration Fee Prior to EHS Funding	**$**
Estimated # of Attendees:	
Reimbursement Requested per Attendee From EHS:	**$** $ 0.00
Conference Registration Fee After EHS Funding	**$** $ 0.00
Total Tuition Reimbursement Requested:	**$** $ 0.00
Payment Issued To:	
Total Amount Approved (DHHS Only):	**$**
Program Approval (DHHS Only):	
Administrator Approval (DHHS Only):	

Upon Conference Completion	
Number of Actual Attendees:	
Total Reimbursement Request: *(not to exceed approved amount)*	**$**
Contact Signature:	
Total Approved (DHHS Only):	**$**
Approved By (DHHS Only):	
AB #(DHHS Only)	
OnBase #(DHHS Only)	

Email completed form and required documentation to
dhhs.sp.EHSContinuingED@nebraska.gov

Revised 2/1/19

Click Here to Save Form after completely filling out form

Clear Form

STATE OF NEBRASKA W-9 & ACH ENROLLMENT FORM

PLEASE SUBMIT FORM TO INVOICED AGENCY

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following boxes:

☐ Individual ☐ Sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate

☐ Non-Profit Entity ☐ Government (Local, State or Federal)

☐ Limited Liability Company. Enter the tax classification (C = C Corporation, S = S Corporation, P = Partnership) ____

☐ Other (see instructions) _____

Note: Enter the owner's name on line 1 and mark the appropriate federal tax classification box for disregarded entities.

4 Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

5 Address:

Remit Address (if different):

6 City, state, and ZIP code

City, state, and ZIP code

Taxpayer Identification Number (TIN):

Social Security Number (SSN): _____-_____-_____ **OR** Employer Identification Number (EIN): _____-_____

Certification:

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding due to failure to report interest and dividend income, and
3. I am a U.S. citizen or other U.S. person (defined in the instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

For additional instructions please refer to http://www.irs.gov/pub/irs-pdf/fw9.pdf to obtain a copy of the IRS Form W-9 General Instructions.

Signature of US Person:_____ Date: _____

Printed Name: _____ Contact Phone:_____

Comments or Business/Entity Notes:

ACH Enrollment: (Rev. December 2014) ☐ Initial Setup ☐ Change ☐ Close Account

This information is REQUIRED to process ACH payments. Without this information, your payment may be delayed.

Financial Institution Name:	Nine Digit Routing Number:	Prior Routing Number: *	☐ Check here if the bank is outside of the United States.
Address:	Depositor Account Number:	Prior Account Number: *	☐ Check here if our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country
City, state and ZIP code:	Type of Account: ☐ Checking ☐ Savings	* Prior ACH instructions are required to be completed if changing/updating your ACH instructions with the State of Nebraska.	

This account will be used for all payments by the State of Nebraska unless specified here: _____

E-mail:_____

(Used for ACH payment notifications.)

Authorized Individual or Entity Signature:	**Attachment Required!** (Select and attach **one** of the following items for verification):
Printed Name:	☐ Blank check (voided) or ☐ Photocopy of a cleared check
Title:	☐ Letter or statement from your financial institution
Date	☐ Vendor invoice or letter which contains printed ACH instructions

Internal Use Only:

Funding for this class has been provided by the

Nebraska Department of Health & Human Services
Office of Emergency Health Systems
Continuing Education Roster – EMS Conference

CONFERENCE TITLE OR TOPIC: _____ DATE: _____

INSTRUCTOR(S): _____ CE HOURS: _____

LOCATION CLASS HELD: _____

Legal Name (please print)	**Organization / Department**	**EMS License Level**	**Signature**
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