EMERGENCY FUND APPLICATION

County ______________________ **Date** ______________________

Time frame of need: __________ **Amount Requested $**__________

I. Statement of the problem:

II. Statement describing plan to solve the problem
(include goals with time frame on a separate sheet):

III. List cost reducing measures already tried and results, include whether you approached other counties:

IV. List sources contacted for other funds and describe results:

V. Describe other initiatives taken or tried to realize additional funds:

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Documents must include, but are not limited to the following:

❏ If not current in the Division of Public Health Nursing and Administration, enclose current copies of P-O2 and CHNS Reports (Community Health Nursing Service Reports, Organization Chart, Functional Job Descriptions for all staff (not classified description)..
CHNS Report must reflect hours spent by staff (Physicians, Nurses, Office Assistants, contracted personnel, etc.) for each activity. For example: using a clinic schedule, show the hours spent by nurse(s) and office assistant(s) plus the number of patients who attended.

-Office Assistants	______%	-Physicians	______%
-Sanitarians	______%	-Nurses	______%
-Contracted personnel	______%		

❏ SG-61 (Environmental Monthly Report)
SG-61 must reflect hours spent by all staff (Sanitarian, Office Assistant, etc.) for each ` activity.

❏ Letter of commitment from the chairperson of the board of health.

❏ Letter of support from the health officer or administrator.

❏ Send a list of all the programs provided by all sections.

❏ Submit the total amounts collected in clinical reimbursable funds, environmental fees and permits for this year and the preceding year.

❏ Check off to complete the following :
Fees for patient services are in place: Yes □ No □
(Attach a copy of your fees) At maximum: Yes □ No □

- Fees for environmental services are in place: Yes □ No □
  (Attach a copy of your fees)

- Fees for permits are in place: Yes □ No □
  (Attach a copy of your fees)

- Raises were given this year: Yes □ No □
  Cost: $__________

- PEIA is paid completely for all staff: Yes □ No□
  Employee: ________%
  Agency: ________%
  Other benefits __________

❏ Contribution from County Commission: $________
From Board of Education: $________
From Municipality: $________
Purchase Service or Direct: ______________ $________

- ❏ County/Municipal levy supports health department: Yes □ No □
  Amount received to date (current year): $________
  Amount budgeted for current year: $________
  Amount received previous year: $________

- ❏ In Kind Contributions: $________________

I certify to the best of my knowledge that all information given above is accurate:

____
Chairperson of Board

____
Health Officer

Mail to : Division of Public Health Nursing and Administration
350 Capitol Street
Charleston, West Virginia 25301-3716

NOTE: If any of the above items are not submitted, please explain.

I certify to the best of my knowledge that all information given above is accurate.

____
Board of Health Chair

____
Health Officer

Conference call contact:

Mail to:
Division of Public Health Nursing and Administration
350 Capitol Street, Room 515
Charleston, WV 25301-3716