

FY2008 EMERGENCY FUND APPLICATION

County _____

Date _____

Fiscal Year _____

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:

Submit the following documentation:

- Current copy PO2, Organization Chart, and Functional Job Descriptions** for all staff (not the classified description).
Personnel Report: to 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.
- SG-61 Environmental Monthly Report:** the 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.**
- Provide a current list of all 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: \$_____

• Total number of employees covered by PEIA: _____

• Of those covered by PEIA what percentage is paid
by: Employee: _____ %
Agency: _____ %

• What other benefits are paid for the employee? _____

Contribution from:

County Commission: \$ _____
Board of Education: \$ _____
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

Conference Call Contact: _____

Mail to : Division of Local Health
350 Capitol Street, Room 515
Charleston, West Virginia 25301-3716

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