DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-47255 (Rev. 05/2019)

STATE OF WISCONSIN
Office of Preparedness and Emergency Health Care
Wis. Stat. § 256.12
608-266-1568

EMS FUNDING ASSISTANCE PROGRAM
MUNICIPAL SIGNATURE AND POPULATION VERIFICATION PAGE

State Fiscal Year (SFY) 2020

(Reporting for SFY 2018: July 1, **2017** through June 30, **2018**)

This page is to be used when completing the separate EMS Funding Assistance Program Application found in E Licensing. This page is not the application, but is to be used to obtain municipal population verifications used in completing the application. These municipal signatures are required under Wis. Stat. § 256.12 in order to receive EMS financial and training assistance. Please scan these completed pages and attach to your electronic application found in E Licensing. If needed, return completed form and necessary attachments to DHSEMSSMail@dhs.wisconsin.gov Fax number is 608 261 6392.

1. AMBULANCE SERVICE PROVIDER INFORMATION

Name of Licensed Provider	Provider No.
Complete mailing address	Telephone No.
Federal Employer ID Number	E-mail address

2. CERTIFICATION OF MUNICIPALITY / CONTRACTING AGENCY(S)

Identify ***all*** municipalities included in your primary service area. Each municipality included in your ***primary service area*** must certify the actual ***population served*** and what ***percentage of the total population*** this represents. Each municipality that you serve as primary 911 patient transport response should have a population certification completed. This is to be done by the municipal clerk.

Municipal Code - The code that is used by the State of Wisconsin to identify the municipality (Usually in the format of XX-XXX)

Population Served – This is the total number of people that are served by the ambulance provider (If the provider covers 25% of a population that is 100 then the population reported should be 25.)

Percentage of total population the above represents – What is the percentage of the total population that is being served in the number above (If the number is 25 of 100 then it should be reported as 25%.

(This page can be copied to use if there are more than one municipality in your primary service area.)

By my signature, I certify that the information provided for the municipality is true to the best of my knowledge. I further certify that funds received under this program by or for the ambulance service provider will not be used to replace or decrease existing funds / budgets.

(Check One) ☐ **County** ☐ **City** ☐ **Village** ☐ **Township** ☐ **Tribal**

Municipality Name			Municipal Code (XX-XXX)
Mailing Address	City	State	Zip Code
Population Served by EMS provider	Percentage of total population represented		
Print Name of Clerk			
SIGNATURE - Clerk		Date Signed	