

Community Paramedicine RFA EMS Agency Funding Application Form

I. General Information

This is the application for the Community Paramedicine Request for Applications (RFA). All sections of this application must be completed in full to be considered for funding and this application form shall not exceed twenty-five (25) pages (excluding attachments or supporting documents). Applicants should refer to the RFA for information regarding application evaluation criteria and refer to the RFA Narrative for detailed information on eligibility, program requirements, and allowable use of funds.

Applicants with questions are encouraged to participate in the biweekly RFA office hours, which provide an opportunity to receive technical assistance and clarification related to the application and program requirements. Details on office hours, including dates, are provided in the RFA Narrative.

Completed applications should be submitted no later than June 12th, 2026, to the Crisis to Care (CTC) Workforce Development Specialist, Jimmie Hampton jimmie.hampton@ky.gov. Please include "RHT CP RFA" in the subject line for all communications.

Late or incomplete applications will **not** be considered for funding.

II. Agency Information

EMS Agency Name:

Agency License Number (KBEMS):

Address:

Service Area:

Agency Type (i.e. government, private, hospital-based, etc.):

Number of Employers/Providers and Service Mix

<ul style="list-style-type: none">• Community Paramedics:• Paramedics:• AEMTs:• EMTs:• EMRs:• Administrative Staff:
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III. Applicant Information

Name:

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Title/Position:

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Email Address:

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Phone Number:

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Date of Application Submission:

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IV. Contact Information

If there are specific staff members or other critical agency stakeholders you would like to receive communications about this project, please provide their contact information. This will help ensure everyone stays informed and up-to-date on project progress and key updates. Copy and paste the table for additional staff or other critical stakeholders, as needed.

Name:

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Title/Position:

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Email Address:

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Phone Number:

V. Community Paramedicine Status

What is your agency's current community paramedicine status? (check off or highlight)

- No Community Paramedicine Program
- Yes, we do have a Community Paramedicine Program (< 2 years)
- Yes, we do have a Community Paramedicine program (\geq 2 years)

VI. Selection of Funding Pathway (check off or highlight choice)

- Pathway #1: Establish a New Community Paramedicine Program
- Pathway #2: Expand an Existing Community Paramedicine Program

VII. Agencies with Existing Community Paramedicine Program

For agencies with an existing community paramedicine program, please fill out the following information. Agencies without an existing community paramedicine program may skip this section.

Current Number of Staffed Community Paramedic(s): _____

Current Annual Community Paramedic Call Volume: _____

List of existing community partnerships (i.e. hospitals, clinics, CMHCs, etc.): _____

Technology Currently Utilized (including software and hardware): _____

VIII. Community Paramedicine Program Evaluation

New and Existing Program Overview

- 1) Describe the problem(s) or unmet need(s) your proposed program seeks to address with these funds. Include relevant community context and explain how the requested funding and your community paramedicine will directly mitigate or address these challenges. Please include how these unmet needs were identified.

2) Please identify and describe the target population(s) of your program will serve. Include key characteristics, needs, and any prioritization criteria, is applicable.

3) Please describe the geographic area(s) in which the proposed program will operate, including service area boundaries and any rationale for selecting these locations.

Scope of Services

- 1) Describe the services that will be provided through the proposed program. Include a brief explanation of how services will be delivered and how they align with identified community needs. Please include any current and proposed behavioral health services.

- 2) Describe the proposed community paramedic staffing model for the program, including roles, responsibilities, credentialing, and anticipated staffing levels.

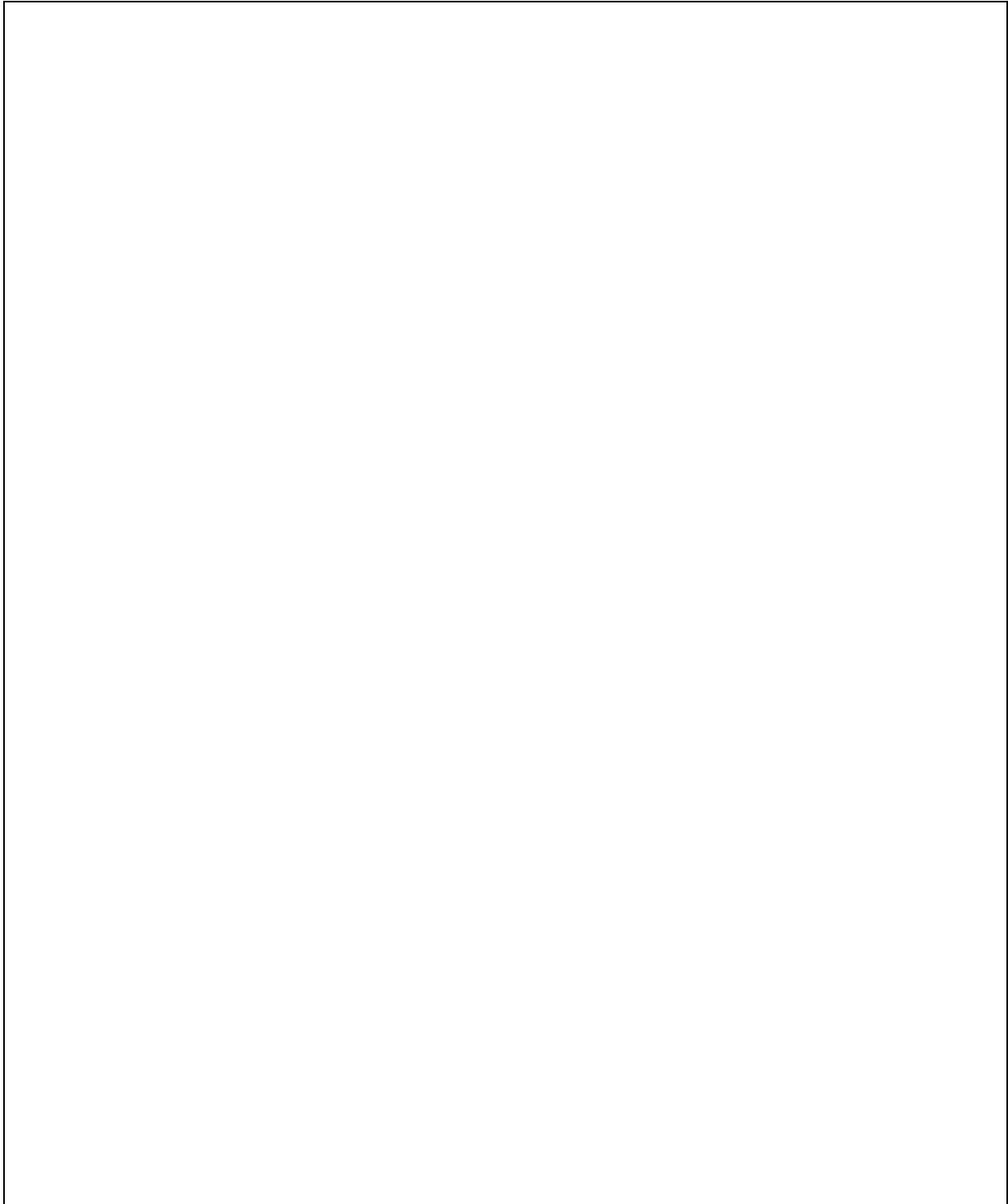
- 3) Describe how patients will be referred to the community paramedicine program and how the program will respond to referrals. Note any referral sources, intake processes, and the response timeline for patient follow-up, as applicable.

- 4) Please list the key community partners that your agency plans to work with for community paramedicine referral pathways?

Example: If your program focuses on community mental health, referral pathways may include 988 call centers and Community Mental Health Centers (CMHCs) for crisis referral, follow-up, and care coordination.

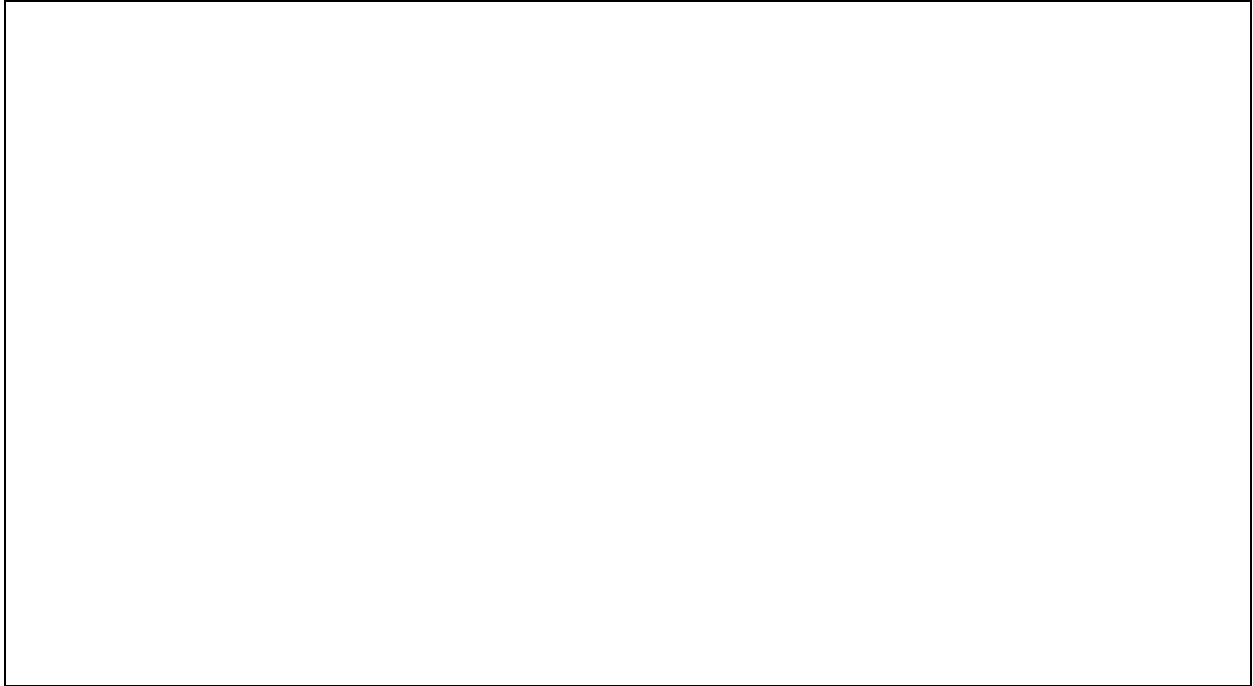
Timeline

- 5) Provide a detailed timeline outlining key activities and milestones for program implementation and operation for the period of August 2026 through July 2027. Timelines should reflect planning, launch, service delivery, and any reporting phases.

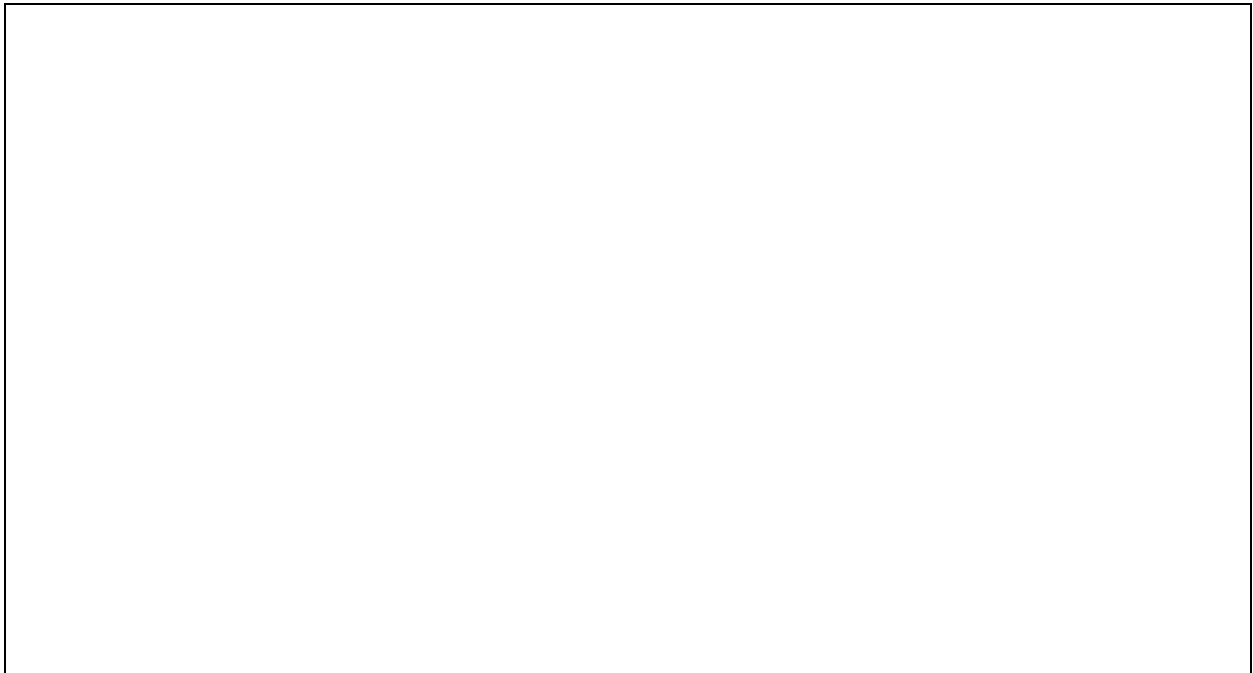
A large, empty rectangular box with a thin black border, occupying the majority of the page below the instruction. It is intended for the user to provide a detailed timeline for the program implementation and operation from August 2026 to July 2027.

Deliverables

- 6) **Community Paramedicine Provider Roster:** This roster is applicable to agencies with an existing community paramedicine program at the time of application.



- 7) **Community Paramedicine Weekly Operational Schedule:** Please submit a current or proposed schedule for the days & hours of community paramedicine operations.



8) Technology Utilization: Please list the software(s) and hardware(s) currently in use or planned to be in future use for your community paramedicine program, including iPads, tough books, PCR software, etc. Please note if any of these tools are specifically intended to bridge existing communication or connectivity gaps.

9) Memoranda of Understanding (MOUs): Include a draft of an MOU to be sent to a community-based partner for community paramedicine program.

- 10) Data Reporting: Include the type of data to be reported throughout this federal budget period. This may include, but is not limited to:
- a. Volume of community paramedics
 - b. Volume of community paramedic patient encounters
 - c. Estimated amount of 'emergent' 911 dispatch calls mitigated through community paramedicine program
 - d. Volume of repeat patient encounters within community paramedicine program



IX. Application Narrative

- 1) Please describe the methodology for launching a community paramedicine program, including key steps, community-based or health-based partnerships, and how non-emergent services will be delivered.

- 2) Please identify potential barriers and describe planned strategies or resolutions to mitigate those barriers.

- 3) Please describe your evaluation plan, outcomes to be measured, data collection measures, and how results (i.e. volume of community paramedicine patient counters) will be used to assess success.

- 4) Please describe your sustainability plan for how the program will continue to operate after start-up funding ends, including demonstrated strength of the program, target community paramedicine patient encounters, anticipated 911 calls avoided, and plan to maintain commitment from community paramedics over time.

X. Application Attachments

(1) Have you attached documentation from agency leadership and/or medical director demonstrating organizational commitment to establishing a community paramedicine program? (check off or highlight choice)

YES

NO

(2) Have you attached a budget for federal FY27 using the provided budget template (“Attachment A”)?

YES

NO

XI. Attestations

You affirm participation in BH training and agree to assign a BH Champion to coordinate within a system of crisis care in partnership with our regional CMHC (identified below in relevant reference links).

AGENCY AFFIRMS

You affirm that your agency will comply with all applicable federal, state, and local laws, regulations, and program requirements related to this funding, including EMS agency licensure and scope of service standards.

AGENCY AFFIRMS

You affirm that all awarded funds will be used solely for allowable purposes as defined in the RFA and associated grant guidance.

AGENCY AFFIRMS

You affirm that all community paramedics and staff under this program will meet required credentialing, training, and certification standards and will operate within their authorized scope of practice.

AGENCY AFFIRMS

You affirm that your agency is in good standing with KBEMS.

AGENCY AFFIRMS

You affirm that your agency will cooperate with monitoring and evaluation activities related to this funding, including providing documentation upon request.

AGENCY AFFIRMS

XII. Relevant Reference Links

Identify your local behavioral health partners, including, Community Mental Health Centers (CMHCs) on the Kentucky Cabinet for Health & Family Services CMHC listing.

XIII. Authorized Agency Representative Signature & Sign Off

Full Name: _____

Position / Title: _____

Signature: _____

Date: _____