

## **Local Board of Health Emergency Fund Application Submission and Review Instructions**

### **Step 1: Application Completion and Submission**

- Complete all fields in the application and provide requested documentation to avoid delays
- The application must be signed in blue ink and dated
- Mail or email the signed application and documentation to the following address:

Center for Local Health  
C/O Emergency Fund  
350 Capitol Street, Room 515  
Charleston, WV 25301  
[Lisa.m.thompson@wv.gov](mailto:Lisa.m.thompson@wv.gov)

### **Step 2: Receipt of Application**

- Upon receipt of the application, a preliminary review will be performed by the Center for Local Health to assure all documentation has been secured.
- Application and supporting documentation will be reviewed by the Emergency Fund Committee.
- Emergency Fund Committee will make recommendation to the Bureau for Public Health Commissioner.
- The Commissioner will make a final recommendation.

### **Step 3: Local Board of Health Emergency Fund Review Committee**

- The Emergency Fund Committee review process may include but is not limited to the following:
  - Conduct a conference call or a site visit with appropriate members of the agency.
  - Contact programs within the Bureau for Public Health pertaining to the agency's performance and reporting history.
  - Request additional supportive documentation from the agency.

### **Step 4: Notification**

- An approval or denial letter will be sent to the local board of health. If approved an invoice will be submitted for expedited processing.
- The Center for Local Health Financial Coordinator will e-mail a scanned copy of the signed letter to the Local Board of Health Chair and Local Health Department Administrator along with sending a hard copy in the mail.

# LOCAL BOARD OF HEALTH EMERGENCY FUND APPLICATION

## APPLICANT INFORMATION

Local Board of Health (BOH) Name:		BOH Chair:
Local Health Department (LHD) Administrator:		LHD Financial Contact:
Local Health Department Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Date: MM/DD/YY

## FINANCIAL INDICATORS

Date of Last Audit:	Auditor Opinion: (7\YW\ One)    Adverse/Disclaimer    Qualified    Unqualified	
State Aid Quarterly Distribution Amount:	Cash/Cash Equivalents:	Net Profit or Loss:
Last Financial Report Submission:	Did your agency issue employee pay raises this fiscal year? (if yes provide amounts)	
Does your Health Department pay for employee benefits such as health insurance? (if yes provide type and amounts)		
Has your Health Department implemented any cost reducing measures this fiscal year? (if yes please explain)		
Has your Health Department implemented any revenue generating measures this fiscal year? (If yes please explain)		

## DESCRIPTION OF EMERGENCY

Provide a brief description of the financial emergency:	
Amount requested to satisfy emergency:	Date funds are needed:
Provide a brief description of plan to resolve emergency including goals and timeframes (provide corrective action plan)	
Has your Health Department requested funds from other sources to satisfy this emergency? (if yes please explain)	

# LOCAL BOARD OF HEALTH EMERGENCY FUND APPLICATION

## LIST OF REQUIRED DOCUMENTATION

Please include the following documentation with this application:

1. Copy of financial statements for the past six months (trial balance and profit and loss).
2. Functional Job Descriptions for all staff (please do not use the classification descriptions).
3. Time and effort reports for all staff and for each program for the past six months.
4. SG-61 Environmental Monthly Report for the past six months: The SG-61 must reflect hours spent by all staff for each activity.
5. Description of the cost allocation method used by your agency.
6. Letter of support from the County Commission.
7. Listing of all programs (Please note any programs with expenditures that exceed dedicated plus self-generated revenues)
8. Corrective Action Plan (include goals and timeframes to resolve emergency)

## CONTACT DETAILS

BOH Chair Name:	Phone:	Email:
LHD Administrator Name:	Phone:	Email:
LHD Financial Clerk:	Phone:	Email:

## SIGNATURES

The information provided on this form is true and accurate to the best of my knowledge.

Signature of Board of Health Chair:	Date:
Signature of Local Health Department Administrator:	Date: