**FISCAL YEAR 2024**

**State 911 Department**

**EMERGENCY MEDICAL DISPATCH GRANT BUDGET MODIFICATION FORM**

**PSAP NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please use this form to request modification of your current authorized budget.**

**Attach narrative and quotes to support budget modification request** and **MAIL** to: **State 911 Department, 151 Campanelli Drive, Suite A, Middleborough, MA 02346**

Reallocation to a category and/or item not previously approved shall be subject to the **prior written approval** of the State 911 Department, and such approval shall be sought and obtained **prior** to implementation of such reallocation. No grantee will receive funding above and beyond its initial contract award. All budget modifications must be submitted in compliance with grant guidelines and approved prior to the contract end date (06/30/2024).

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| --- |
| **Primary PSAP, Regional PSAP, Regional Secondary PSAP, & RECC** |
| **CATEGORY** | **CURRENT****APPROVED BUDGET****(A)** | **Indicate Add or Reduce****+/-** | **AMENDED AMOUNT****(B)** | **NEW BUDGET AMOUNT****(C=A +/– B)** |
| 1. Certified EMD Resource | $ |  | $ | $ |
| 2. Emergency Medical Dispatch Protocol Reference System | $ |  | $ | $ |
| 3. Other Emergency Medical Dispatch and Quality Assurance of Emergency Medical Dispatch Services  | $ |  | $  | $ |
|  |  |  |  |  |
| **TOTAL \*** | $ |  |  | $ |

**\*Total Amount must be equal to contract award amount.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Quote & Narrative Attached Signature, Authorized Signatory Date**
* **New Item – No adjustment to category budget**