

## BLS FUNDING

### MOBILE INTEGRATED HEALTHCARE (MIH)

**Mobile Integrated Healthcare (MIH)** programs connect low-acuity and vulnerable EMS clients to the appropriate resources to address their complex needs through alternative response and referral strategies. The region collectively identified extending MIH services to all parts of the King County as a top priority for the 2020-2025 levy span.

- BLS agencies receive funding to provide MIH services. Agencies may choose to run their own program, or partner with other nearby agencies to create a larger effort.
- MIH funding must be used only for MIH services; it is not intended to fund existing BLS, ALS, or fire services
- The funding is a reimbursement, meaning the agency invoices the EMS Division for repayment up to the amount allocated that year. The EMS Division determines and regularly updates guidance on MIH-eligible expenses.
- Agency funding levels mirror those of the BLS allocation, based 50% on assessed valuation (AV) and 50% on call volumes.
- Agencies implementing MIH will support good regional stewardship of the program through close collaboration with the EMS Division and other King County MIH programs at the MIH stakeholder meetings (MIH Network) and by adhering to the MIH Program Guidelines established by the EMS Division.

**If you have any questions about the MIH program**, please contact Marlee Fischer at 206-263-6956 or [marfischer@kingcounty.gov](mailto:marfischer@kingcounty.gov).

**2020 - 2025 BLS Invoice – Mobile  
Integrated Healthcare (MIH)**

Fire Agency Name

Exhibit: B4 – MIH Invoice and Budget Summary

Contract Period: 1/1/2020 to 12/31/2025

Fire Agency Name

Address 1

Address 2

Name, Title

(111) 111-1111

[email@email.com](mailto:email@email.com)

EMS Division Invoice Contact:

Marlee Fischer ([marfischer@kingcounty.gov](mailto:marfischer@kingcounty.gov))

Public Health—Seattle & King County

Emergency Medical Services Division

401 5<sup>th</sup> Ave., Suite 1200

Seattle, WA 98104

ALL FIELDS MUST BE COMPLETED FOR PROMPT PAYMENT PROCESSING

**King County Accounts Payable Information**

Purchase Order #

Supplier Name

Supplier #

Supplier Pay Site

Remit to Address

Invoice Date

Invoice #

Amount to be Paid

Note to AP

Payment Type (Circle One) CHECK or ACH

Print on Remittance

PH Program Name &

Phone

Invoices for services rendered under  
this contract for the period of:

Start Date	End Date
MM/DD/YY	MM/DD/YY

For Public Health Use Only				
	Rcv'd	FM Review	Entered	Approved
Date				
Initial				

Project	Organization	Expend Acct	Task	Award	DPH Acct	CPA	CFDA	Amount
1137930	830500	53180	002	101752				

Attach sheet for multiple POETAs

Direct Costs	Budget	Billed to Date	Current Report	Cumulative	Balance
<b>Personnel Costs</b>	\$	\$	\$	\$	\$
Salaries	--	--	\$	\$	--
Overtime	--	--	\$	\$	--
Benefits	--	--	\$	\$	--
<b>Program Support</b>	\$	\$	\$	\$	\$
Supplies & Uniforms	--	--	\$	\$	--
Planning	--	--	\$	\$	--
Training	--	--	\$	\$	--
<b>Vehicle/Vehicle Support</b>	\$	\$	\$	\$	\$
<b>Technology/Reporting</b>	\$	\$	\$	\$	\$
<b>Professional Services</b>	\$	\$	\$	\$	\$
<b>Total Direct Costs</b>	\$	\$	\$	\$	\$

<b>Grand Total</b>	\$	\$	\$	\$	\$
			<b>Amount Due</b>		

I, the undersigned, do hereby certify under the laws of the State of Washington penalty of perjury that this is a true and correct claim for reimbursement services rendered. I understand that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and State laws. This certification includes any attachments which serve as supporting documentation to this reimbursement request.

Signed

Date

PH Program Manager Approval

Date

Print Name