



**Municipality:** Simsbury

## Form NAA-01

### 2018 Connecticut Neighborhood Assistance Act (NAA) Program Proposal

This form **must** be completed and submitted to your municipality for approval. All items **must** be completed with as much detail as possible. If additional space is needed, attach additional sheets. Please type or print clearly. See attached instructions before completing. **Do not submit this form directly to the Department of Revenue Services.**

#### Part I — General Information

Name of tax exempt organization/municipal agency: \_\_\_\_\_  
Simsbury Volunteer Ambulance Association, Inc.

Address: P.O. Box 301, 4 Old Mill Lane, Simsbury CT

Federal Employer Identification Number: 06-6062402

Program title: Ambulance Replacement

Name of contact person: Michael Delehanty

Telephone number: (860) 658-7213

Email address: mdelehanty@simsburyems.com

**Total NAA funding requested** (\$250 minimum, \$150,000 maximum): \$ 133,644.00

Is your organization required to file federal Form 990 or 990EZ, Return of Organization Exempt from Income Tax?

Yes       No

If **Yes**, attach a copy of the **first page** of your most recent return.

If **No**, attach a copy of your determination letter from the U.S. Treasury Department, Internal Revenue Service.

## Part II — Program Information

Check the appropriate description of your program:

### 100% credit percentage

- Energy conservation; or  
 Comprehensive college access loan forgiveness (see Conn. Gen Stat. §12-635(3)).

### 60% credit percentage

- Job training/education for unemployed persons aged 50 or over;  
 Job training/education for persons with physical disabilities;  
 Program serving low-income persons;  
 Child care services;  
 Establishment of a child day care facility;  
 Open space acquisition fund; **or**  
 Other (specify): Emergency Medical Services, Not for Profit Agency

Description of program: \_\_\_\_\_

SVAA is the provider of Emergency medical Services in the Town of Simsbury. We will not receive funding from the Town. As a 501c3 organization, SVAA solicits donations.

This new ambulance will replace an older vehicle in daily service. SVAA has held a capital fund drive by direct mail for the purpose of funding this new ambulance purchase. We realized net proceeds of \$46,356 from this campaign. As the balance of the funding is realized, we anticipate the design and production of the ambulance will be completed in approximately twelve months.

Need for program: \_\_\_\_\_

Current ambulance has approximately 150,000 miles and must be replaced. Due to development trends, and a growing and aging Town population, SVAA has seen a steady increase in EMS calls over the last five years. This has led to a need to operate a second ambulance during the peak hours, and has accelerated the ambulance replacement schedule.

Neighborhood area to be served: \_\_\_\_\_

Simsbury, with mutual aid to Canton, Granby and East Granby

Plan to implement the program: \_\_\_\_\_

Large and medium sized businesses will be solicited for donations under this program. This program will be administered by staff and volunteers at SVAA.

**Timetable:**

Program start date: 12/23/17

Program completion date: 12/23/19

**The program completion date must not be more than two years from the program start date. A certified post-project review is due to the municipality overseeing implementation no later than three months after program completion date for all projects receiving \$25,000 or more in NAA funding.**

**Part III — Financial Information**

**Program Budget:**

Complete in full. Expenditures must equal or exceed total funding.

**Sources of Revenue:**

NAA funds requested \$133,644.00

Other funding sources - itemized sources:

a) Capital fund drive- direct mail \$50,775.00

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

**Total Funding:** \$184,419.00

**Proposed Program Expenditures:**

Direct operating expenses - itemized description:

a) Direct mail funding appeal \$4,419.00

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

Administrative expenses - itemized description:

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

**Total Proposed Expenditures:** \$4,419.00

**Part IV — Municipal Information**

**To be completed by the municipal agency overseeing implementation of the program**

Name of municipal agency overseeing implementation of the program: _____ Town of Simsbury _____
Mailing address: _____ 933 Hopmeadow Street, Simsbury CT 06070 _____
Name of municipal liaison: <u>Melissa Appleby, Deputy Town Manager</u> _____
Telephone number: <u>860-658-3230</u>
Fax number: <u>860-658-9467</u>
Email address: <u>mappleby@simsbury-ct.gov</u> _____

<p style="text-align: center;"><b>Post-Project Review</b></p> <p style="text-align: center;">Is a post-project review required for this proposal?</p> <p style="text-align: center;"><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p style="text-align: center;">If <b>Yes</b>, date post-project review due:</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Date</p>
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# 2018 Connecticut Neighborhood Assistance Act (NAA) Program Proposal Instructions

Complete all items on **Form NAA-01**, *2018 Connecticut Neighborhood Assistance Act (NAA) Program Proposal*. Incomplete applications will **not** be accepted. Direct inquiries to Department of Revenue Services (DRS), Neighborhood Assistance Act Program, Attn: Research Unit, 450 Columbus Blvd Ste 1, Hartford CT 06103-1837, or call **860-297-5687**.

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## Part I General Information

Enter the name of the tax exempt organization or municipal agency, address, Federal Employer Identification Number, and email address.

**Program Title:** Assign a unique program title to each program for which your organization is making an application.

**Federal Form 990:** Attach a copy of the first page of your organization's most recent federal Form 990 or Form 990EZ. If your organization is not required to file either Form 990 or Form 990EZ, attach a copy of the determination letter from the Internal Revenue Service.

## Part II Program Information

**Description of Program:** Describe the program, including information about how the program will operate, its benefit to the community, how recipients will be selected, and any measures used to determine the program's impact on the community.

**Need for Program:** Demonstrate a need for this program. For example, provide relevant statistics.

**Neighborhood Area to Be Served:** Describe the neighborhood or municipality this program will serve.

**Plan to implement the program:** Describe how the program will operate. Identify other persons or organizations involved in the administration of the program.

**Timetable:** Indicate the starting and completion dates of the program. The program completion date must not be more than two years from the program start date.

## Part III Financial Information

Each program proposal must include a program budget that includes all sources of funding and all anticipated expenditures. The information provided in the budget may be used during a post-project audit.

**Sources of Revenue:** The budget must include the requested NAA funding and any other anticipated revenue sources.

**NAA Funding Requested:** Indicate the total amount your organization is requesting for its program. This amount may not exceed the total proposed expenditures. Please note that the minimum NAA funding is \$250, with a maximum funding of \$150,000 per organization or agency per year.

**Other Funding Sources:** Provide a detailed description(s) and the amount(s) of all funding sources.

**Proposed Program Expenditures:** The budget must include a detailed description and the amount of all direct operating and administrative expenditures. **Expenditures must equal or exceed total funding.**

**Direct Operating Expenses:** Expenses include materials, equipment, wages, salaries, tuition fees, sub-contracting services, and any other expenses needed to administer the program.

## Part IV Municipal Information

This part is to be completed by the municipal agency overseeing implementation of the program.

**Municipal Liaison:** The municipality must designate an individual to serve as a liaison with DRS for all NAA matters.

**Post-Project Review:** Any program receiving \$25,000 or more in NAA funding is required to provide a post-project review, prepared by a certified public accounting firm, to the municipality overseeing the program. This review must be submitted to the municipality no later than three months after the program completion date.

# Return of Organization Exempt From Income Tax

**2017**

Open to Public Inspection

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

**A** For the 2017 calendar year, or tax year beginning \_\_\_\_\_, and ending \_\_\_\_\_

**B** Check if applicable:  
 Address change  
 Name change  
 Initial return  
 Final return/terminated  
 Amended return  
 Application pending

**C** Name of organization **SIMSBURY VOLUNTEER AMBULANCE ASSOC, INC.**  
 Doing business as \_\_\_\_\_  
 Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
**P.O. BOX 301, 4 OLD MILL LANE**  
 City or town State ZIP code  
**SIMSBURY CT 06070**  
 Foreign country name Foreign province/state/county Foreign postal code

**D** Employer identification number  
**06-6062402**

**E** Telephone number  
**(860) 658-7213**

**G** Gross receipts \$ **952,703**

**F** Name and address of principal officer:  
**MICHAEL DELEHANTY P.O. BOX 301, 4 OLD MILL LANE, SIMSBURY,**  
 H(a) Is this a group return for subordinates?  Yes  No  
 H(b) Are all subordinates included?  Yes  No  
 If "No," attach a list. (see instructions)

**I** Tax-exempt status:  501(c)(3)  501(c) ( ) ◀ (insert no.)  4947(a)(1) or  527

**J** Website: **WWW.SIMSBURYEMS.COM** H(c) Group exemption number ▶ \_\_\_\_\_

**K** Form of organization:  Corporation  Trust  Association  Other ▶ \_\_\_\_\_ L Year of formation: **1957** M State of legal domicile: **CT**

Part I Summary			
Activities & Governance	<b>1</b> Briefly describe the organization's mission or most significant activities: <b>PROVIDE EMERGENCY MEDICAL SERVICES</b>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>7</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>7</b>
	<b>5</b> Total number of individuals employed in calendar year 2017 (Part V, line 2a)	<b>5</b>	<b>17</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>0</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	<b>0</b>	
Revenue	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	<b>9</b> Program service revenue (Part VIII, line 2g)	81,074	147,106
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	895,588	805,389
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,416	208
	<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	978,078	952,703
Expenses	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1–3)	0	0
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	628,083	597,466
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ <b>8,752</b>		
	<b>17</b> Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	368,805	462,665
<b>18</b> Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	996,888	1,060,131	
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	-18,810	-107,428	
Net Assets or Fund Balances	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	<b>21</b> Total liabilities (Part X, line 26)	1,674,327	1,577,423
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	76,482	87,006
		1,597,845	1,490,417

**Part II Signature Block**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

**Sign Here**

Signature of officer \_\_\_\_\_ Date \_\_\_\_\_

Type or print name and title \_\_\_\_\_

**Paid Preparer Use Only**

Print/Type preparer's name Preparer's signature Date Check  if self-employed PTIN  
**MICHAEL SOLAKIAN MICHAEL SOLAKIAN 4/18/2018 P01260810**

Firm's name ▶ **SOLAKIAN AND COMPANY, LLC** Firm's EIN ▶ **46-1036695**  
 Firm's address ▶ **P.O. BOX 716, NORTH BRANFORD, CT 06471** Phone no. **(203) 483-8115**

May the IRS discuss this return with the preparer shown above? (see instructions)  Yes  No