

**Application for Financial Assistance to Partially Fund Towns, Cities, or Mosquito Control District's  
Mosquito Control Activities**

**Division of Public Health Services  
New Hampshire Department of Health and Human Services**

**Application**

The application must provide the information outlined below.

1. GENERAL INFORMATION
2. EXPENSES AND AMOUNT REQUESTED
3. COPIES OF MOSQUITO CONTRACTOR INVOICES DETAILING SERVICES (LARVICIDING AND/OR ADULTICIDING) BY DATE
4. COMPREHENSIVE MOSQUITO CONTROL PLAN FILING DATE
5. FUNDING REQUEST JUSTIFICATION

**Application Submittal**

Submit a completed application via mail or hand-deliver to the address below before December 1 of the calendar year in which expenses were incurred.

Arboviral Surveillance Coordinator  
The Department of Health and Human Services  
Division of Public Health Services  
29 Hazen Drive  
Concord, NH 03301-6504

**Award Notification and Acceptance/Denial**

NH DHHS will issue a Letter of Award to the recipient town, city, or MCD representative within 30 working days of December 1, indicating funding granted/not granted and reason for the decision.

**Communicating with the NH DHHS**

If you have any questions please contact Beth Daly, Disease Surveillance Section Chief, (603) 271-4927 or Dianne Donovan, Infectious Disease Epidemiologist, (603) 271-5927.

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**For Internal Use Only**

Date Received: \_\_\_\_\_

Date PH Threat Declared: \_\_\_\_\_

Reviewed by (initial & date): \_\_\_\_\_

Approved by (initial & date): \_\_\_\_\_

Paid by (initial & date): \_\_\_\_\_

**Application for Financial Assistance to Partially Fund Towns, Cities, or Mosquito Control District's Mosquito Control Activities**

**GENERAL INFORMATION**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Town/City Name \_\_\_\_\_  
(Names of all incorporated towns if MCD): \_\_\_\_\_

Name and title of individual filing the application: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Authorized Signature: I verify that information contained in this application is accurate, and I am authorized to sign on behalf of the above named town or city.

\_\_\_\_\_  
Signature Printed Name and Title

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For MCDs a representative from each incorporated town/city must sign (attach additional sheets as necessary):

\_\_\_\_\_  
Signature Printed Name, Title, Town/City

\_\_\_\_\_  
Signature Printed Name, Title, Town/City

\_\_\_\_\_  
Signature Printed Name, Title, Town/City

\_\_\_\_\_  
Signature Printed Name, Title, Town/City

## EXPENSES AND AMOUNT REQUESTED

Town/City Name(s): \_\_\_\_\_

Submission Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

List below the documented expenses incurred on mosquito control (larvicide and/or adulticide) directed at the public health threat. (Note: a public health threat must be declared by the Commissioner of NH DHHS for the submitting town/city). Expenses eligible for reimbursement include personnel (contracted and employees), mosquito control products, and expenses incurred in application of the control products. Expenses incurred before and/or after the declaration of the public health threat are eligible for reimbursement. Please complete the following summary tables AND attach a detail listing (receipts or invoices where applicable) for all expenses.

<b>Contractual Service For Mosquito Control</b>	
Contractor's Name: _____	
Address: _____	
Type of Service Provided: _____	
Expense Category (eligible costs only)	AMOUNT
Personnel	\$
Mosquito Control Products	\$
Mosquito Control Equipment/Application	\$
Other	\$
<b>TOTAL ELIGIBLE EXPENSES</b>	<b>\$</b>
Amount of funding requested (Cannot exceed 25% of total eligible expenses)	\$

<b>Internal Personnel For Mosquito Control</b>	
Expense Category (eligible costs only)	AMOUNT
Personnel	\$
Mosquito Control Products	\$
Mosquito Control Equipment/Application	\$
Other	\$
<b>TOTAL ELIGIBLE EXPENSES</b>	<b>\$</b>
Amount of funding requested (Cannot exceed 25% of total eligible expenses)	\$

\_\_\_\_\_  
Prepared by (name, title)

\_\_\_\_\_  
Telephone Number

**COMPREHENSIVE MOSQUITO CONTROL PLAN**

Mosquito Control Plan previously submitted on \_\_\_\_/\_\_\_\_/\_\_\_\_ has been carried over into current year.

Updated/New Mosquito Control Plan submitted to DHHS on \_\_\_\_/\_\_\_\_/\_\_\_\_.

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**FUNDING REQUEST JUSTIFICATION**

Town/City Name(s): \_\_\_\_\_

Submission Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provide a justification for the request, including an explanation/discussion why your current resources are insufficient. (You may attach additional pages as needed.)