State of Montana – Dept. of Administration

Public Safety Communications Bureau

PSAP Name: _____

PSAP Address: _____

_____ **Zip:**_____

Primary Contact Number for PSAP: _____

Name and Title of PSAP Manager/Administrator/Coordinator:

_____

Email Address: _____

Mailing Address: _____

_____ **Zip:** _____

Telephone: _____ **Fax:** _____

State of Montana Tax ID: _____

State of Montana Vendor Number: _____

Federal Communications ID: _____

NENA ID: _____

REQUIREMENTS: The 2018 PSAP Certification is required to be completed for each local government entity that hosts a primary PSAP. Please note that your certification will not be complete until all supporting documentation is received. A copy of the following documentation must be included when submitting the PSAP Certification:

1. **Valid, signed agreement between jurisdictions**
2. **If applicable, signed agreement between PSAP and local tribe**

Applicant:

_____

1. I am a/the _____ of the Applicant named above.

2. I am authorized to act on behalf Applicant.

3. Applicant is a properly constituted city, town, or consolidated city-county government pursuant to the laws of the State of Montana.

4. Applicant hosts a public safety answering point as defined in 10-4-101, MCA.

5. Applicant operates a 9-1-1 system meeting the minimum requirements of 10-4-103, MCA.

6. Applicant first receives all emergency wireline and wireless voice calls from persons requesting emergency services in the public safety answering point's service area.

7. Applicant meets the requirements of Title 10, chapter 4, MCA, and ARM Title 2, chapter 13, subchapter 3 and will operate the 9-1-1 system in accordance with these requirements.

I declare under penalty of perjury that the foregoing is true and correct.

_____

Signature

_____

Date

_____

Printed Name

_____

Title

_____

Applicant Name

_____

If multiple local government entities are participating in a 9-1-1 system and will receive distributions from the Applicant, please complete the following for each local government entity.

Applicant:

_____

1. I am a/the _____ of the Applicant named above.

2. I am authorized to act on behalf of Applicant.

3. Applicant has entered into a valid agreement regarding use and distribution of payments from the 9-1-1 systems account with:

_____

(List Participating Entity)

I declare under penalty of perjury that the foregoing is true and correct.

_____

Signature

_____

Date

_____

Printed Name

_____

Title

_____

Applicant Name

If multiple local government entities are participating in a 9-1-1 system and will receive distributions from the Applicant, please complete the following for each participating local government entity.

Participating Entity:

_____

1. I am a/the _____ of the Participating Entity named above.

2. I am authorized to act on behalf of Participating Entity.

3. Participating Entity is a properly constituted city, town, or consolidated city-county government pursuant to the laws of the State of Montana.

4. Participating Entity is participating in a 9-1-1 system with Applicant, which has applied to be a certified PSAP.

5. Participating Entity has entered into a valid agreement with Applicant regarding use and distribution of payments from the 9-1-1 systems account.

I declare under penalty of perjury that the foregoing is true and correct.

_____

Signature

_____

Date

_____

Printed Name

_____

Title

_____

Participating Entity Name

If a tribal government is participating in a 9-1-1 system and will receive distributions from the Applicant, please complete the following for each tribal government.

Applicant:

_____

1. I am a/the _____ of the Applicant named above.

2. I am authorized to act on behalf of Applicant.

3. Applicant has entered into an agreement regarding use and distribution of payments from the 9-1-1 systems account with:

_____

(List Participating Tribal Government)

I declare under penalty of perjury that the foregoing is true and correct.

_____

Signature

_____

Date

_____

Printed Name

_____

Title

_____

Applicant Name

If a tribal government is participating in a 9-1-1 system and will receive distributions from the Applicant, please complete the following for each participating tribal government.

Tribal Government:

_____

1. I am a/the _____ of the Tribal Government named above.

2. I am authorized to act on behalf of Tribal Government.

3. Tribal Government is one of the seven federally recognized tribal governments of Montana and the Little Shell Tribe of Chippewa Indians.

4. Tribal Government is participating in a 9-1-1 system with Applicant, which has applied to be a certified PSAP.

5. Tribal Government has entered into an agreement with Applicant regarding use and distribution of payments from the 9-1-1 systems account.

I declare under penalty of perjury that the foregoing is true and correct.

_____

Signature

_____

Date

_____

Printed Name

_____

Title

_____

Tribal Government