

# **SECTION III GRANT APPLICATION**

Complete the following application using the forms provided.

**AGENCY NAME:** \_\_\_\_\_

**SECTION A  
DELINEATION OF VEHICLE NEEDS**

1. Please check the description that best fits your plan for the proposed vehicle(s).
  - A. \_\_\_\_\_ Purchase of Section 5310 vehicle with previously acquired Section 5310 vehicle being retained as a spare which expands agency's fleet **(sign-offs required)**
  - B. \_\_\_\_\_ Purchase of Section 5310 vehicle with previously acquired Section 5310 vehicle being sold
  - C. \_\_\_\_\_ Purchase of Section 5310 vehicle to expand fleet **(sign-offs required)**
  - D. \_\_\_\_\_ Purchase of Section 5310 vehicle with non-Section 5310 vehicle being sold
  - E. \_\_\_\_\_ Purchase of Section 5310 vehicle with non-Section 5310 vehicle being retained as a spare which expands agency's fleet **(sign-offs required)**

**NOTE:** All vehicle(s) to be **replaced**, must have at least 90,000 miles of service at the time of application submission.

**NOTE:** The Division of Public Transit will allow one spare vehicle for agencies that have a fleet size of 1-5 and two spare vehicles for agencies that have a fleet size of 6-12.

**Describe in detail:**

How existing transportation services are unavailable, insufficient or inappropriate for your clients:

How the requested vehicle will overcome these shortcomings:

Steps the applicant will take to ensure that this project does not duplicate any existing service:

## SERVICE AREA

2. The "transportation service area of the Project is intended to include the geographic area over which the Project is operated and the area whose population is served by the Project, including adjacent areas affected by the Project." Please answer these questions using 2010 Census information for each county in your service area. (Sources: Census.gov; American Fact Finder; American Community Survey Five-Year Estimates)

Description of Service Area: (State exactly where requested vehicle is going to be utilized. From what location (center) will the vehicle be dispatched into what areas?)

3. Total population of service area \_\_\_\_\_

Source of information \_\_\_\_\_

4. Total disabled population of service area \_\_\_\_\_

5. Senior population of service area \_\_\_\_\_

6. Number of total clients within the following groups:

\_\_\_\_\_ Black    \_\_\_\_\_ Asian or Pacific Islands    \_\_\_\_\_ Hispanic    \_\_\_\_\_ American Indian or Alaskan Native

7. Is your agency a minority organization?    Yes \_\_\_\_\_    No \_\_\_\_\_

8. Does your agency provide assistance to minority communities?

Yes \_\_\_\_\_    No \_\_\_\_\_

Describe your assistance:

9. Are any other local transit systems and/or authorities (excluding Boards of Education or Greyhound) operating within the area delineated in Question #2? Check appropriate blank.

Yes \_\_\_\_\_    No \_\_\_\_\_

10. Are taxi companies operating within the area delineated in Question #2?  
Check appropriate blank.

Yes \_\_\_\_\_

No \_\_\_\_\_

11. Are other private non-profit organizations currently providing transportation services within the area delineated in Question #2? Check appropriate blank. (Do not include your agency.)

Yes \_\_\_\_\_

No \_\_\_\_\_

12. Check the statement which best describes the type of transportation services within the area delineated in Question #2?

\_\_\_\_\_ a. Seniors and individuals with disabilities within your service area will depend almost entirely upon your agency for their transportation in addition to that required for them to utilize and/or participate in the services and activities of the agency.

\_\_\_\_\_ b. Seniors and individuals with disabilities within your service area will be provided transportation by your agency only to the extent necessary for them to utilize and/or participate in the service activities of your agency.

13. Type of clients served:

% Non Disabled Senior \_\_\_\_\_ % Physically Disabled Senior \_\_\_\_\_

% Mentally Disabled Senior \_\_\_\_\_ % Physically Disabled Non Senior \_\_\_\_\_

% Mentally Disabled Non Senior \_\_\_\_\_ % Other \_\_\_\_\_

14. Number of both senior and non senior disabled individuals to be **served weekly** by the **vehicle(s) you have requested?** \_\_\_\_\_

15. Number of senior individuals to be **served weekly** by the vehicle(s) you have requested? **(Do not count an individual twice - an individual is either disabled or senior, not both.)** \_\_\_\_\_

16. Total number of persons **served weekly** by **all of the vehicles in your current fleet?**

17. Check the days of the week and indicate the hours of operation of your agency's **transportation program**.

\_\_\_ M \_\_\_                      \_\_\_ Th \_\_\_                      \_\_\_ Su \_\_\_  
\_\_\_ Tu \_\_\_                      \_\_\_ F \_\_\_  
\_\_\_ W \_\_\_                      \_\_\_ Sa \_\_\_

**SECTION B  
VEHICLE UTILIZATION**

18. How many hours per day will the **vehicle(s) requested** actually be in operation?

Vehicle #1 \_\_\_                      Vehicle #2 \_\_\_                      Vehicle #3 \_\_\_

19. How many vehicles does your organization **currently** own and/or lease?

Own \_\_\_                      Lease \_\_\_

20. How many vehicles are **currently** used for the transportation of elderly persons and/or persons with disabilities? \_\_\_\_\_

21. How many spares does your agency have? \_\_\_\_\_

22. Have satisfactory procedures been established to provide "back-up" transportation when regular vehicles are out of service?

Yes \_\_\_                      No \_\_\_

Describe your procedures:

23. Indicate by percentages what type of transportation will be provided with the **vehicle being requested**.

\_\_\_ % Adult Day Care                      \_\_\_ % Mental Health  
\_\_\_ % Education                      \_\_\_ % Nutrition  
\_\_\_ % Employment                      \_\_\_ % Shopping/Personal  
\_\_\_ % Medical                      \_\_\_ % Social/Recreation  
\_\_\_ % Other \_\_\_\_\_

- 24. How many runs (one way trips) will be made daily with the **vehicle being requested** to bring clients into your agency's site? \_\_\_\_\_
- 25. How many runs (one way trips) will be made daily with the **vehicle being requested** to take clients home from your agency's site? \_\_\_\_\_
- 26. Anticipated daily mileage for **vehicle being requested**? \_\_\_\_\_
- 27. List the serial number(s) and mechanical condition of the vehicle(s) that will be replaced.

	Serial Number(s)	Make/Model Year	Mileage	Mechanical Condition
Vehicle #1	_____	_____	_____	_____
Vehicle #2	_____	_____	_____	_____

- 28. Average yearly mileage of **current fleet**? \_\_\_\_\_
- 29. Average age of **current fleet**? \_\_\_\_\_

The Americans With Disabilities Act of 1990 requires that persons with disabilities receive the same level of service from a transportation provider as a non-disabled person.

- 30. If you do not have lift-equipped vehicles in your inventory, do you have a written agreement with another provider in your service area to provide a lift-equipped vehicle when needed?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give name, contact person, address and telephone number of agency:

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# CURRENT VEHICLE INVENTORY

A new requirement now exists for agencies receiving funding from the Section 5310 Program. If your agency provides regular, continuing shared-ride surface transportation services that are open to the general public or open to a segment of the general public defined by age, disability or low income then an **inventory of all vehicles that are used by your agency to provide transportation services** is required to be submitted to the Division (*regardless of original funding source*).

The Division is required by the Federal Transit Administration to gather total vehicle inventory for inclusion in a Statewide Transit Asset Management Plan (TAM). The TAM Plan must be completed for the Division to be eligible to receive Section 5310 funds.

As an example, 5310 providers who provide open service to all seniors in a town, **must be included in the plan**. If your agency only provides rides to seniors who are registered with the senior center or nutrition center then it is deemed closed door and does not need to be included in the TAM Plan. This same philosophy must be applied to all 5310 grantees (mental health, sheltered workshop, etc.) to determine if your agency is closed or open to your segment of the general population.

The above example is the best I have for your agency to decide whether you are an open or closed transportation provider. If your agency is receiving contracted services funding from the Division or NEMT, then you are an open transportation provider.

1. Page 22 is a certification that is to be signed in blue and returned as part of your application packet. **The Division must provide justification to FTA if a 5310 recipient is not included in the plan. (All agencies must complete certification.)**
2. Complete the Current Vehicle Inventory Chart on the next page. **List all your agency's vehicles that are used to provide transportation services (*regardless of original funding source*)**. All columns must be completed. Condition Code Definitions are provided. Attach additional sheets if necessary. If you serve multiple counties, down right side of table, add county vehicle is utilized in.
3. **If you are an open transportation provider, for vehicles purchased/donated using other funding sources, a copy of the title of the vehicle is also required to be submitted (this will provide entry of the correct serial number into the TAM Plan.)**

## Transit Asset Management Plan Certification

The \_\_\_\_\_ hereby certifies that our agency:  
(Name of Agency)

\_\_\_\_\_ provides regular, continuing shared-ride surface transportation services that are open to the general public or open to a segment of the general public defined by age, disability or low income and will provide all required inventory information as requested.

or

\_\_\_\_\_ only provides rides to clients who are registered with our agency and is deemed closed door providing no transportation services to other segments of the general public.

\_\_\_\_\_  
(Authorized Official)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Agency Name)





## CONDITION CODE DEFINITIONS:

Rank	Category	Description
5	Excellent	Brand new, no major problems exist, only routine preventive maintenance
4	Good	Elements are in good working order, requiring only nominal or infrequent minor repairs (greater than 6 months between minor repairs)
3	Fair	Requires frequent minor repairs (less than 6 months between repairs) or infrequent major repairs (more than 6 months between major repairs).
2	Poor	Requires frequent major repairs (less than 6 months between major repairs).
1	Bad	In poor condition that continued use presents potential problems.

31. What procedures do persons with disabilities (persons who use wheelchairs, have visual impairments, hearing impairments, communication disabilities, etc.) use to access your agency's transportation service? Are these procedures different than for a non-disabled person?
32. Has your agency ever received a request for transportation services from a person who uses a wheelchair, has a visual impairment, hearing impairment, communication disability, etc.? If yes, how did you provide this service? Be specific.

### **SECTION C COORDINATION EFFORTS**

33. Does your agency currently participate in a cooperative/coordinated effort in your area?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the arrangement and specify the type of trips shared; number of clients served; and any other cooperative activities, such as; joint training; joint purchasing; joint grant writing, etc.

If no, please explain

34. Will the **vehicle requested** be used to provide transportation services for Welfare to Work Programs?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe services to be provided.

### **COORDINATION WITH OTHER FEDERAL PROGRAMS**

The U.S. Department of Transportation (U.S. DOT) signed an interagency agreement with the U.S. Department of Health and Human Services (DHHS) in 1996 to improve the coordination of programs funded by the two departments. States are to encourage their Section 5310 recipients to participate in coordinated systems at the local level, along with recipients of funds from the programs of DHHS. The State must sign an assurance that the consolidated program of projects submitted for funding provides for maximum feasible coordination of transportation services assisted under Section 5310 with transportation services assisted by other Federal sources.

Also, the Older Americans Act now has provisions that affect community transportation services. There is strengthened language describing expectations for coordination of senior-oriented and public transportation services under the "Title III-B" supportive services and senior centers program.

35. Describe the processes that your agency undertakes to ensure that the proposed transportation services are or will be coordinated to the maximum extent possible with other federally funded agencies and private transportation providers in the proposed service area? Refer to the 2014 West Virginia Transportation Providers Directory and specifically address how you have coordinated with providers in your service area.

**Locally Developed Coordinated  
Public Transit-Human Services  
Transportation Plan**

All projects funded by the Enhanced Mobility of Seniors and Individuals With Disabilities Formula Program (Section 5310) must be part of a “locally developed coordinated public transit-human services transportation plan.” This plan was required to be developed through a process that included representatives of public, private, and non-profit transportation service providers, human services transportation providers and the general public.

All known transportation agencies were notified that any agency planning on applying for funding under the Section 5310 Program, anytime within the next four years, had to **PARTICIPATE IN THE PLAN DEVELOPMENT AND ATTEND THE DEVELOPMENT MEETINGS!**

Regional Planning and Development Councils across the state facilitated the development of the Coordinated Public Transit-Human Services Transportation Plans for each region and continue to update the plans periodically. The Councils held meetings in your Region, surveyed agencies and ask for input.

36. Did someone from your agency attend focus group meetings facilitated by RLS & Associates and the WV Division of Public Transit?

Yes \_\_\_\_\_ No \_\_\_\_\_

Name of person(s) attending: \_\_\_\_\_  
\_\_\_\_\_

Location(s) of meeting: \_\_\_\_\_

37. Was your agency requested to complete a survey in regards to the plan?

Yes \_\_\_\_\_ No \_\_\_\_\_

38. Did your agency complete the survey? Yes \_\_\_\_\_ No \_\_\_\_\_

39. Is your agency involved in any new coordination activities as a result of these efforts? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe:

### SECTION D FISCAL AND MANAGERIAL CAPABILITIES

40. Indicate the statement which describes the availability of local funds to defray your operating expenditures. The funds required by this organization to operate your existing and proposed new vehicles **over the next five years** are:
- a. \_\_\_\_\_ A certainty because of the stability of the income source.
  - b. \_\_\_\_\_ Reasonably secure but because several of the sources are subject to variation, the operational expenses are not guaranteed.
  - c. \_\_\_\_\_ Fairly uncertain because all funding sources are not reliable or guaranteed.

### SECTION E OPERATING PLAN

41. \_\_\_\_\_  
Maintenance Program

Do you have a vehicle maintenance plan which at least meets the minimum recommendations of the vehicle manufacturer?

Yes \_\_\_\_\_ No \_\_\_\_\_

42. Is there a daily pre-trip vehicle inspection program in place?

Yes \_\_\_\_\_ No \_\_\_\_\_

Describe:

43. Are deficiencies noted in pre-trip inspections repaired in a timely manner and properly reviewed by management?

Yes \_\_\_\_\_ No \_\_\_\_\_

44. If you utilize vehicles which have tie-down mechanisms for wheelchairs/ramps, how often are these checked to insure proper operation?

45. If you utilize vehicles that are lift/ramp equipped, how often is it being cycled even when it is not used?

Daily\_\_\_\_\_ Weekly\_\_\_\_\_ Monthly\_\_\_\_\_ Never\_\_\_\_\_

46. Maintenance Facilities (Check **the one** that best describes your program)

a. \_\_\_\_\_ You have your own maintenance facilities and personnel that can handle any repairs required on the vehicles.

b. \_\_\_\_\_ You have facilities and personnel that can handle routine maintenance and tune-ups. Major repairs would be contracted out on an as needed basis.

c. \_\_\_\_\_ You have a maintenance contract which provides the required maintenance for all of your agency's vehicles.

d. \_\_\_\_\_ You will contract out, on an as needed basis, for required maintenance.

47. Storage: Where will the vehicle you are applying for be stored?  
(Check **only one**.)

a. \_\_\_\_\_ The vehicle will be stored at an indoor facility located at \_\_\_\_\_.

b. \_\_\_\_\_ The vehicle will be stored at an outside but secured area located at \_\_\_\_\_.

c. \_\_\_\_\_ The vehicle will be stored at the home of the driver.

d. \_\_\_\_\_ No special storage provisions have been made at this time.

e. \_\_\_\_\_ Other (Please explain) \_\_\_\_\_.

48. Driver Selection (check all that apply)

When selecting your drivers, does your agency...

- a. \_\_\_\_ Check their driving record? ( valid, appropriate vehicle operator's license, eligible for insurance coverage?)
- b. \_\_\_\_ Require a physical examination?
- c. \_\_\_\_ Require driving experience with vehicles similar to those operated for your agency or satisfactory completion of a training program prior to actual passenger transportation?
- d. \_\_\_\_ Require a pre-employment drug/alcohol test?

49. Driver Training: Describe your agency's **driver orientation program**:

50. List the types and amount of **driver training** your agency has provided within the last two years:

51. Describe any **safety training** your agency has provided within the last two years (evacuation procedures, safety plans):

52. What type of safety materials does your agency provide to it's drivers?



53. Does your agency have an on going driver safety program? \_\_\_ Yes \_\_\_ No

54. The Americans With Disabilities Act requires training of all drivers. Please list all drivers from your organization who have had Passenger Service and Safety Training (PASS) and are still driving.

**Provide copies of training certificates**

Name of Driver(s)	Still Employed?	
	Y	N

Attach additional sheets if necessary.

55. Please list all drivers from your organization who **have not** had PASS training.

56. Have your drivers received Operation Lifesaver Training (**Railroad Crossing Awareness Training**)? \_\_\_ Yes \_\_\_ No

57. Has your agency prepared a transportation safety plan or yearly update using the S.P.I.D.E.R. materials?

\_\_\_ Yes \_\_\_ No

58. Does your agency have a communication system?

\_\_\_ Yes \_\_\_ No

If yes, please check type:

Mobile Radios \_\_\_ CB \_\_\_ Pager \_\_\_ Cellular Phone \_\_\_

Other \_\_\_ (specify) \_\_\_\_\_

Explain dispatch procedures used with communication equipment.

59. If your agency does not have a communication system, please check the appropriate choice below:
- a. \_\_\_\_\_ One person will be assigned as dispatcher and he/she will handle van schedules and assign drivers. The dispatcher will also be responsible for assigning replacements for drivers failing to report to work.
  - b. \_\_\_\_\_ The dispatcher will be a part time job assigned to one of our staff members.
  - c. \_\_\_\_\_ No one has been assigned, the job will be handled on an as needed basis.

60. Why should this application be funded?

**61. If your agency is selected for funding, list below your agency's name and phone number as it should appear on the side of an approved vehicle. Should your agency not want it's name or phone number on the side of an approved vehicle, please state so below.**

62. If your agency is selected for funding, would it prefer one or two tie down spaces for wheelchairs in the vehicle? (See Section Q for more details)

One Tie-Down                       Two Tie-Downs

63. If your agency is selected for funding, would it prefer cloth or vinyl passenger seats?

Cloth                       Vinyl

64. If your agency is selected for funding, would you like a child restraint seat provided with your vehicle?  Yes                       No

65. If your agency is selected for funding, would you like a security camera system, including playback system, for inside the van (if available) for your requested van? The estimated cost is \$5,000 per van with your estimated 20% being \$1,000.  Yes                       No

## SUMMARY OF PROJECT COSTS

VQVCN'RTQLGEV'EQUVU'O C[ 'DG'O QTG'QT'NGUU'VJ CP'RTQLGEV'GUVKO CVG'

AMOUNT

- A. Total Estimated Vehicle Cost (See Section Q for choices) \$
- B. Contingencies (5% of A)
- C. Storage and Security Costs (\$150 x # of vehicles)
- D. Total Estimated Cost (A + B + C)
- E. Federal Grant Request (80% of D)
- F. Local Contribution (20% of D)

**Sources and amounts of 20% local share for the equipment being requested:**

SOURCE	AMOUNT
_____	_____
_____	_____
_____	_____

Local match may be derived from any **Non** US Department of Transportation Federal Program, State Programs, Local Contribution or Grants.

Attach documentation of vehicle match funds immediately behind this page. Proof may consist of, but not be limited to: written statements from county commissions, state agencies, city managers, mayors, town councils, organizations, accounting firms and financial institutions.

**All of the above must be notarized and show the date that these funds become available.**

**OPERATING BUDGET OF VEHICLE REQUESTED**

ANNUAL COST

- A. Salaries and Fringe Benefits \$ \_\_\_\_\_
- B. Overhead (Rent and other) \_\_\_\_\_
- C. Fuel, Lubricants and Tires \_\_\_\_\_
- D. Maintenance \_\_\_\_\_
- E. Insurance \_\_\_\_\_
- F. Contract Service \_\_\_\_\_
- G. Administrative and Reporting Costs \_\_\_\_\_
- H. Other \_\_\_\_\_

**TOTAL ESTIMATED ANNUAL COST** \$ \_\_\_\_\_

Sources and amounts of proposed annual operating budget for the requested vehicle(s).

SOURCE	AMOUNT
_____	_____
_____	_____
_____	_____
_____	_____

**Attach notarized documentation of local operating support immediately behind this page.**

## **SECTION IV**

# **COMMUNICATION EQUIPMENT APPLICATION**

## CHECKLIST FOR COMMUNICATION EQUIPMENT

- \_\_\_\_\_ Letter of Intent
- \_\_\_\_\_ Title Page
- \_\_\_\_\_ Authorizing Resolution (**SIGNED IN BLUE INK**)
- \_\_\_\_\_ Verification Certification (**SIGNED IN BLUE INK**)
- \_\_\_\_\_ Articles of Incorporation (IRS Tax Exemption letter is not acceptable.)
- \_\_\_\_\_ Positive Local Intergovernmental Review  
" " **(MANDATORY AT TIME OF SUBMISSION)**  
**(must approve communication equipment purchase)**
- \_\_\_\_\_ Certifications (**SIGNED IN BLUE INK**)
- \_\_\_\_\_ Application for Communication Equipment (Questions 1 - 17)  
**Include Equipment Specifications**
- \_\_\_\_\_ Appendix S - Title VI Nondiscrimination and Limited English Proficiency  
**(Must Utilize Provided Format)**
- \_\_\_\_\_ **Notarized** Proof of Necessary Local Matching

# APPLICATION FOR COMMUNICATION EQUIPMENT INSTRUCTIONS

When applying for communication equipment (two-way radio), an agency is required to provide the information shown on the previous checklist. This information is to be provided based on the instructions given in the application packet. Also, an agency applying for communication equipment is required to provide the following additional items:

1. Projected cost of equipment.
2. Equipment specifications - **The applying agency is required to obtain from a communication equipment vendor and submit.**
3. Proof that the equipment will not interfere with current communication facilities in agency's service area (i.e. - interference to television, radio station, or ambulance radio equipment.)

An agency is required to follow the same time frame as applicants applying for vehicles. Applications for funds to purchase communication equipment are due on or before **June 21, 2019.**

**Citizen's band radios, cellular phones and AM and/or FM radios**  
**ARE NOT ELIGIBLE FOR FUNDING**



## APPLICATION FOR COMMUNICATION EQUIPMENT

Agency Name: \_\_\_\_\_

1. Service Area: \_\_\_\_\_

2. Service Area (**check only one**)

a. \_\_\_\_\_ Predominantly Urban

b. \_\_\_\_\_ Predominantly Rural

c. \_\_\_\_\_ Mixed

3. Service Area (**check only one**)

a. \_\_\_\_\_ Countywide

b. \_\_\_\_\_ Localized

4. Number of agencies (including your own) providing transportation to elderly persons and persons with disabilities in your service area:

a. \_\_\_\_\_ 1-2

b. \_\_\_\_\_ 3-5

c. \_\_\_\_\_ 6 or more

5. Number of taxi companies in your service area:

a. \_\_\_\_\_ 0

b. \_\_\_\_\_ 1

c. \_\_\_\_\_ 2 or more

6. Is there a public transit system in your service area?

a. \_\_\_\_\_ YES

b. \_\_\_\_\_ NO

7. Most recent funding under a Section 5310 grant:
- a. \_\_\_\_\_ 2018
  - b. \_\_\_\_\_ 2017
  - c. \_\_\_\_\_ 2016 or earlier
- \_\_\_\_\_
8. Dispatching (**check only one**)
- a. \_\_\_\_\_ One person will be assigned as dispatcher and will handle vehicle scheduling and driver assignments.
  - b. \_\_\_\_\_ Dispatcher will be a part-time job assigned to one or more staff members.
  - c. \_\_\_\_\_ No dispatcher will be assigned. The job will be handled on an as-needed basis.
9. Number of Vehicles in Your Fleet \_\_\_\_\_
10. Number of Radios Requested \_\_\_\_\_
11. Explain why communication equipment (radios) is needed by your agency.  
(If more room is needed, use another page.)
12. What is the estimated cost of the communication equipment requested?  
Include all costs (i.e. radios, base stations, towers, license fees, repeater service, hookups, etc.) **(Agencies should determine what their operating cost such as monthly access fees, etc. will be.)**

**13. SUMMARY OF PROJECT COSTS**

**TOTAL PROJECT COSTS MAY BE MORE OR LESS THAN THE PROJECT ESTIMATES**

- A. Total Estimated Radio Equipment Costs (from Question #12)     \$ \_\_\_\_\_
- B. Contingencies (5% of A)     \_\_\_\_\_
- C. Total Estimated Cost (A + B)     \_\_\_\_\_
- D. Federal Grant Request (80% of C)     \_\_\_\_\_
- E. Local Contribution (20% of C)     \_\_\_\_\_

14. Sources and amounts of 20% local share for the radio equipment being requested:

SOURCE	AMOUNT
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL	\$ _____

Local match maybe derived from the **Non** U.S. Department of Transportation Federal Program, State Programs, Local Contributions, or Grants.

15. Attach notarized proof of local match and operating funds. Proof may consist of, but not be limited to: written statements from county commissions, state agencies, city managers, mayors, town councils, organizations, accounting firms and financial institutions.

**All proof must be notarized and show the date when these funds will be available.**

**NOTE: These funds must be from non-Federal sources, or if applicable, eligible Federal sources!**

16. **Attach communication equipment specifications prepared by a communication equipment vendor.**

17. **Attach statement from communication equipment vendor verifying that your requested equipment will not interfere with current communication facilities in agency's service area (i.e. interference to television, radio station, or ambulance radio equipment.)**

## COMMUNICATION EQUIPMENT MAINTENANCE CERTIFICATION

The \_\_\_\_\_ agrees to  
**(Agency Name)**

maintain and operate in good working condition any communication equipment  
purchased with Section 5310 funds.

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Authorizing Signature)**