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

_______% Education

_______% Employment

_______% Medical

_______% Other ________________________________

_______% Mental Health

_______% Nutrition

_______% Shopping/Personal

_______% Social/Recreation

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:
____
____

CURRENT VEHICLE INVENTORY

Complete the Current Vehicle Inventory Chart on Page 22 from application packet. List all of your agency's vehicles that are used to provide transportation services. Attach additional sheets if necessary.

CURRENT VEHICLE INVENTORY
(Please List Each Vehicle Separately)

Vehicle Make Model	Vehicle Serial Number	Model Year	Current Mileage	Seating Capacity	Special Equipment (Lift or Ramp)	Funding Source For Purchase	Spare Vehicle (Yes/No)	Utilized In What County

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 Contribuition 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 **August 31, 2017.**

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. _____ 2016

    b. _____ 2015

    c. _____ 2014 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)**