|  |  |
| --- | --- |
| **Complete Application Checklist for OPERATING Projects**  ***All Attachment files should be clearly named prior to upload.*** | |
| **ü** | **Application Narrative Responses** |
|  | **General Information** |
| **Part I – Applicant Profile** | |
|  | **Agency Information** |
|  | **Agency Geographic Area** |
|  | **Applicant Profile** |
|  | **Audited Financial Statement** |
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|  | **Proposed Local Match Source for Operating Requests** |
|  | **Requested Programming Year** |
|  | **Detailed Mobility Management and Operating Assistance Funding RequestsQuestions** |
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| **Part III – Scored Questions** | |
|  | 1. **Goals and Objectives** |
|  | 1. **Project Implementation** |
|  | 1. **Program Performance Indicators** |
|  | 1. **Coordination, Outreach, and Sustainability** |
|  | 1. **Emergency Planning and Preparedness** |
| **Part IV – Certifications** | |
|  | **Private Non-profit Agency – Corporation Status Inquiry** |
|  | **Private Non-profit Information** |
|  | **Public Agency Certification** |
|  | **Certification of No Readily Available Service Providers** |
|  | **General Certifications and Assurances** |
|  | **Coordinated Plan Certification** |
|  | **Application Certification** |
| **Attachments – List attachments below as needed, expand upon if necessary** | |
|  | Attachment 1: Purpose and Program Supporting Documentation |
|  | Attachment 2: Agency Geographic Area |
|  | Attachment 3: Audited Financial Statement |
|  | Attachment 4: Transportation Needs Assessment for Seniors and Individuals with Disabilities |
|  | Attachment 5: Match Source Documentation |
|  | Attachment 6: Operating Assistance/Mobility Management Plan Supporting Documentation |
|  | Attachment 7: Transportation Services Assessment and Client Needs Analysis |
|  | Attachment 8: Letters of Support |
|  | Attachment 9: Private Non-profit Agency – Corporation Status Inquiry Documentation |
|  | Attachment 10: Private Non-profit Information |
|  | Attachment 11: Proof of a Public Hearing Notice or Formal Letter Certification |
|  | Attachment 12: Certification of No Readily Available Service Providers Documentation |
|  | Attachment 13: |

## **General Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Agency (Applicant) Legal Name: |  | | | |
| Physical Address (No P.O. Box): |  | | | |
| City, County, ZIP: |  | | | |
| Applicant Contact Name: |  | | | |
| Applicant Contact Title: |  | | | |
| Email: |  | | Phone: |  |
| Alternate Contact: |  | | | |
| Alternate Email: |  | | Phone: |  |
| Application Type:  *Please indicate Capital or Operating* | **OPERATING** | | | |
| Project Title: |  | | | |
| Phase of Work that request would support (New Services, Service Expansions, Service Restoration, Mobility Management, Driver and Travel Related Trainings, and First-and-Last Mile Connections, etc.) Be sure to include a brief description for each item: |  | | | |
| Brief Project Description – Include an explanation of the type of service, management, training, or connections being provided with applicable details: |  | | | |
| Total EMSD Request | **$** |  | | |
| Total Project Cost (Match included) | **$** |  | | |
| Application Priority to applicant agency: | *(For example: Priority 1 of 2)* | | | |

# **Part I – Applicant Profile**

## **Agency Information**

Briefly describe your agency’s purpose and program. **Include days and hours of the operation of your transportation program** and the services your agency currently provides or intends to provide. Supporting documentation must be attached (e.g., agency brochure). *Attachment 1 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

## **Agency Geographic Area**

|  |
| --- |
| Service Area *(briefly indicate areas served by proposed project, additional detail should be provided in the required map attachment)* |
| **Type response here.** |

Please attach a clear and high-quality map delineating the service boundaries of your agency and relevant to this application. *Attachment 2 included?  Yes  No*

## **Applicant Profile**

Provide the total number of clients currently served by the agency, and provide a breakdown of those who are seniors, disabled, or a wheelchair user. **If a client can be identified in more than one category, choose the one category that is most limiting to the client.**  A client is counted only once. For example, an elderly person who uses a wheelchair would be counted **once**, as a wheelchair user.

*A person with disabilities is someone of any age who is not able to use fully accessible public fixed-route services, whether temporarily or on a long-term basis, regardless of whether they need to use a wheelchair. Race/Ethnicity/National Origin information is collected for reporting purposes.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Total number of clients currently served by your agency’s transportation program (*do not duplicate or double count*) | | | Race/Ethnicity/National Origin served by your program by percentage. (Total 100%) | | | |
| Number of seniors |  | | American Indian & Alaska Native | |  | % |
| Number of individuals w/disabilities |  | | Asian | |  | % |
| Number of wheelchair/lift users |  | | Black or African American | |  | % |
| **TOTAL NUMBER OF CLIENTS** |  | | Hispanic or Latinx | |  | % |
|  | | | Native Hawaiian & Pacific Islander | |  | % |
| Middle Eastern or North African | |  | % |
| White & European American | |  | % |
| Total number of wheelchair/lift clients |  | | All Other | |  | % |
| divided by clients |  | % | Specified Race: |  |  | % |
| **TOTAL MUST BE 100%** | | | | |  | **%** |

**Annual Operating Budget**

|  |  |  |  |
| --- | --- | --- | --- |
| **Estimated Income** | | | |
| 1. Passenger Revenue: | | $ |  |
| 1. Other Revenue: | | $ |  |
| 1. Total Grants[[1]](#footnote-2), Donations, Subsidies from Other Agency Funds: | | $ |  |
| **TOTAL INCOME** | | $ |  |
| **Estimated Expenses** | | | |
| 1. Wages, Salaries and Benefits (non-maintenance personnel) | | $ |  |
| 1. Maintenance & Repair (salaries and estimated costs for current and requested vehicles/equipment) | | $ |  |
| 1. Fuels | | $ |  |
| 1. Casualty & Liability Insurance | | $ |  |
| 1. Administrative & General Expense | | $ |  |
| 1. Other Expenses (e.g., materials & supplies, taxes) | | $ |  |
| 1. Contract Services (specify): |  | $ |  |
| **TOTAL EXPENSES** | | **$** |  |

**Operating Fund Sources**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Operating Fund Sources** | | **Prior Year** | | **Current Year** | | **Next Year** | |
|  |  | $ |  | $ |  | $ |  |
|  |  | $ |  | $ |  | $ |  |
|  |  | $ |  | $ |  | $ |  |
|  |  | $ |  | $ |  | $ |  |
| **TOTAL OPERATING** | | | | | | **$** |  |

## **Audited Financial Statement**

Attach a copy of your agency’s **current** (i.e., within the last 2 years) **audited financial statement** showing no instance of non-compliance as an attachment. Provide a summary of the results/findings. *Attachment 3 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

## **Title VI and ADA Requirements and Complaints**

Describe any lawsuits or complaints against your **entire agency** within the last year alleging Title VI discrimination on the basis of race, color, or national origin, and/or any lawsuits or complaints in regard to the Americans with Disability Act. At a minimum, please include the date and description of complaint(s) or lawsuit(s), and current status. **A written response is required**. N/A is not an acceptable response.

|  |
| --- |
| **Type response here.** |

## **Project Need**

The Orange County Enhanced Mobility for Seniors and Disabled (EMSD) grant program is intended to enhance the mobility of seniors and individuals with disabilities by providing local transportation funding to meet the transportation needs of seniors beyond traditional public transportation and individuals with disabilities.

1. **Check the appropriate box below as applicable. One box must be checked.**

**Insufficient:** Available public transportation and paratransit services are insufficient to meet the needs of the target population or equipment needs replacement to ensure continued service (i.e., service at capacity; service parameters, routes, hours and/or needs are not met due to eligibility and/or trip criteria; projected future need; lack of or need of additional accessible vehicles, etc.).

**Inappropriate:** Target population has needs that are difficult or impossible to serve on available public transportation and/or paratransit.

**Existing Transit Service**

1. *Please describe how existing public transit or paratransit, including fixed-route, ADA complementary paratransit and private paratransit does not meet the needs of your senior and disabled clients.*

|  |
| --- |
| **Type response here.** |

1. Describe the transportation needs of seniors and individuals with disabilities to be served by the proposed project. **This is an** assessment of transportation needs for individuals with disabilities or seniors which may be based on the experience and perceptions of the planning partners or on more sophisticated data collection efforts, and gaps in service. *Attachment 4 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

# 

# **Part II – Funding Request**

## **Funding Request Summary**

|  |  |
| --- | --- |
| Step 1: | Check and complete the funding request summary form below to summarize all projects proposed under the operating project category. If you are requesting multiple projects under a category, please make copies of the tables for each project as applicable.   * Mobility Management * Operating Assistance |
| Step 2: | Complete and attach a separate project budget for each of your proposed projects. |

Are you a current recipient of any of the following funds?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***FTA 5310*** | ***Jobs Access and Reverse Commute/New Freedom*** | | | ***Senior Mobility Program (Project U)*** |
| ***Community Circulator (Project V)*** | | ***Other:*** |  | |

Have you also submitted a Capital Project application under this year’s EMSD grant program?  *Yes  No*

## **Application Funding Request Summary** – Note: Fill in once remaining section is completed

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Project Component** | **Total Project Cost**  **(Request + Match)** | | **Match** | | **Match %[[2]](#footnote-3)** | | **Funding Request[[3]](#footnote-4)**  **(Total - Match)** | | **Indirect Cost (10% maximum)** | | **Contingency (5-10%)** | |
| **Operating Assistance** | $ |  | $ |  |  | % | $ |  | $ |  | $ |  |
| **Mobility Management** | $ |  | $ |  |  | % | $ |  | $ |  | $ |  |
| **TOTAL** | **$** |  | **$** |  |  | | **$** |  | **$** |  | **$** |  |
| Please note that the total funding request **per applicant** may not exceed $1.5 million. | | | | | | | | | | | | |

## **Proposed Local Match Source for Operating Requests**

|  |  |  |
| --- | --- | --- |
| **Project Component** | **Local Match Amount**  **(consistent with previous table)** | **Local Match Sources** |
| **Operating Assistance** |  |  |
| **Mobility Management** |  |  |

## **Requested Programming Year**

|  |  |  |
| --- | --- | --- |
| Please indicate in which Fiscal Year (FY) funding is planned to be requested. Note that applicants may request programming funds for FY 2024/25, 2025/26, or 2026/27 **ONLY** (fiscal years ending June 30). See the Timely-Use of Funds Section of the guidelines for more information. | | |
| Operations Programing FY Request | FY |  |
| Mobility Management Programming FY Request | FY |  |

## **Detailed Mobility Management and Operating Assistance Funding Requests**

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding Request for Mobility Management** **(MM)[[4]](#footnote-5)** | | | |
| Scope:  *Include service period.* | | | |
| **Activity** | **Brief Description** | **Cost** | |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
| Subtotal | | $ |  |
| **Indirect Costs – Activity** | **Brief Description** | | |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
| Indirect Subtotal (No greater than 10% of the total project cost) | | $ |  |
| Contingency Line Item (to account for changes due to cost increases, project delays, etc..) 5-10% | | $ |  |
| **TOTAL REQUEST FOR MOBILITY MANAGEMENT** | | **$** |  |
|  | | | |
| **Funding Request for Operating Assistance (OA)4** | | | |
| Scope:  *Include service period.* | | | |
| **Activity** | **Brief Description** | **Cost** | |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
| Subtotal | | $ |  |
| **Indirect Costs – Activity** | **Brief Description** | | |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
|  |  | $ |  |
| Indirect Subtotal (No greater than 10% of the total project cost) | | $ |  |
| Contingency Line Item (to account for changes due to cost increases, project delays, etc..) 5-10% | | $ |  |
| **TOTAL REQUEST FOR OPERATING ASSISTANCE** | | **$** |  |
|  | | | |
| **TOTAL COST OF PROJECT[[5]](#footnote-6)** | | **$** |  |

## **General Questions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Indicate the type(s) of proposed transportation service for the project. (Check all that apply.) | | | | | |
| *Expansion of existing paratransit service beyond the minimum requirements of ADA* | | | *New mobility management project* | | |
| *New or continuation of paratransit service beyond the minimum requirements of ADA* | | | *Expansion of existing driver and/or travel training project* | | |
| *Expansion of an existing mobility management project* | | | *New driver and/or travel training project* | | |
| *First and last mile trips* | | |  | | |
| 1. Is the proposed project an expansion of current service supported by a prior funding award from OCTA? | | | | | |
| *No  Yes* – Provide grant program and agreement number: | | | | |  |
|  | | | | | |
| 1. Does your agency intend to use a third-party contractor for the proposed project service? | | | | | |
| *No  Yes* | | | | | |
| 3a. If yes, is your contract on file with OCTA? | | | | | |
| *N/A  No  Yes* – If yes, Provide the name of the vendor and agreement number below: | | | | | |
|  | | | | | |
| 3b. If yes, what is the operating period of the existing third-party service contract? | | | | | |
| *N/A* |  | | | | |
| What was the service period: | |  | | | |
| 3c. Is there a written option in the contract to extend beyond the base years? | | | | | |
| *N/A  No  Yes* – Identify page/paragraph number: | | | |  | |

# **Part III – Scored Questions**

## **Goals and Objectives (10 Points)**

1. Briefly describe a detailed project description. Please include service operating period (up to a maximum of two years of service) Provide the following information as it pertains to this project – information can be found at <https://www.census.gov/quickfacts/fact/table/US/PST045219>. (3 Points – 3-High, 2-Medium, 1-Low)

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Total Population (number of people) in Your Service Area: |  | | people. |
| 1. Number of Eligible Individuals with Disabilities Served by This Project: | |  | | people. |
| **Type response here.** | | | | | |

1. Briefly describe how your proposed project is consistent with the goals and objectives of the EMSD grant program for Operating Projects as stated in the Program Goals of the Application Instructions. Specify how your proposed project is included in the current Orange County Public Human Services Transportation Coordination Plan (Coordinated Plan) by referencing the relevant goal, objective and/or strategy. (Indicate the section/page numbers). A copy of the Coordination Plan is available for review at: <https://www.octa.net/pdf/HumanServicesTransportation.pdf>.  
   (5 Points – 5-High, 4-Medium-High, 3-Medium, 2-Medium-Low, 1-Low)

|  |
| --- |
| **Type response here.** |

1. Explain how the project meets the program requirement of providing transportation related activities and/or service beyond those required by the ADA. Describe how the project increases or enhances the availability of transportation of the targeted population. (2 Points – Appropriate, 1-Adaquate, 0-Inadequate)

|  |
| --- |
| **Type response here.** |

## **Project Implementation (15 Points)**

1. For Operating Assistance projects, describe your operational plan that includes defined routes, schedules, current/projected ridership, key personnel, and marketing strategies. For Mobility Management projects, describe your implementation plan that includes project tasks timeframes, benchmarks, key milestones, key personnel, deliverables and estimated completion dates. Attach supporting documentation to substantiate this plan(s).   
   (8 Points – 8-High, 6-Medium-High, 5-Medium, 4 Medium-Low, 2-Low) *Attachment 6 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

1. Please describe how your current services have met your prior performance goals and objectives. How is this project proposal different than what is existing, and what do you intend to accomplish with the new funding?   
   (7 Points – 7-High, 5 to 6-Medium-High, 4-Medium, 2 to 3-Medium-Low, 1-Low)

|  |
| --- |
| **Type response here.** |

## **Program Performance Indicators (10 Points)**

1. Please provide the performance measures and objectives for your proposed project(s) below. Check and complete applicable project category. (2 Points – Appropriate, 1-Adaquate, 0-Inadequate)

|  |  |  |  |
| --- | --- | --- | --- |
| **Operating Assistance Annual Performance Measures and Objectives** | | | |
| Existing Service | | | |
| *Current Geographic Coverage* | Number of one-way trips per day: | |  |
| *Current Service Hours/Days* | Number of new miles (one-way) on weekdays: | |  |
| *Current System Capacity* | Number of new miles (one-way) on weekends: | |  |
| *Current access/Connections* |  | | |
| Service Expansion | | | |
| *Current Geographic Coverage* | Number of one-way trips per day: | |  |
| *Current Service Hours/Days* | Number of new miles (one-way) on weekdays: | |  |
| *Current System Capacity* | Number of new miles (one-way) on weekends: | |  |
| *Current access/Connections* |  | | |
| **Mobility Management** | | | |
| *Mobility Management* | | Number of customer contacts: |  |
| Number of one-way trips: |  |
| *One Stop Center/Customer Referral* | | Number of customer contacts: |  |
| *Trip/Itinerary Planning* | | Number of customer contacts: |  |
| *One-on-One Travel Training* | | Number of people trained |  |
| *Group Training* | | Number of people trained: |  |
| *Internet-Based Information* | | Number of web hits: |  |
| *Information Materials/Marketing* | | Description of materials/distribution: |  |
| *Driver Training* | | Number of drivers trained: |  |

1. Identify the performance measures/indicators to track the effectiveness of your project and include the number of people you anticipate being served, and the number and purpose of trips that the project will provide (and other measurable units of service). Include the desired outcome (impact) that the project will have on the target community. (5 Points – 5-High, 4-Medium-High, 3-Medium, 2-Medium-Low, 1-Low)

|  |
| --- |
| **Type response here.** |

1. Based on the performance objectives/ outcomes that you provided in the question C.2, describe methodologies and procedures for ongoing monitoring and evaluation of the project or service. (3 Points – 3-High, 2-Medium, 1-Low)

|  |
| --- |
| **Type response here.** |

## **Coordination, Outreach, and Sustainability (11 Points)**

1. Describe the available non-profit, public transit, or paratransit, including fixed route, ADA complementary paratransit services available in your agency’s geographic area, and identify the relevant section/page number of the Coordinated Plan. Describe the transportation needs of your senior and disabled clients to be served by the proposal and identify the relevant section/page number of the Coordinated Plan. (2 Points – Appropriate, 1-Adaquate, 0-Inadequate)

*Attachment 7 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

1. List all stakeholders involved in the proposed project. Describe how the project will be coordinated with other social service agencies and/or public transportation providers. (e.g., sharing vehicles, dispatching, scheduling, maintenance, coordinating client trips, training, etc.) Attach your letters of support from stakeholders to the grant application. (3 Points – 3-High, 2-Medium, 1-Low) *Attachment 8 included?  Yes  No*

|  |
| --- |
| **Type response here.** |

1. What outreach was done with your senior and disabled clients to demonstrate the need for this project? How was the feedback incorporated into the proposed project(s)? (3 Points –3-High, 2-Medium, 1-Low)

|  |
| --- |
| **Type response here.** |

1. Please describe your outreach methods with your senior and disabled clients to ensure their needs are being met and adjustments to service are made accordingly. Describe the strategies for sustaining this program beyond the two-year funding cycle. (3 Points –3-High, 2-Medium, 1-Low)

|  |
| --- |
| **Type response here.** |

## **Emergency Planning and Preparedness (4 Points)**

1. What policies and procedures does your agency have in place to address emergency planning and preparedness? Has your agency participated in Countywide or Citywide emergency drills in the past year?

(4 Points – , 4-High, 3-Medium-High, 2-Medium-Low, 1-Low)

|  |
| --- |
| **Type response here.** |

# **Part IV – Certifications**

## **Private Non-profit Agency – Corporation Status Inquiry**

The EMSD grant program is intended to enhance mobility for seniors and individuals with disabilities by providing local transportation funding to private non-profit organizations, or to public agencies where no private non-profits are readily available to provide the proposed service.

To document eligibility as an EMSD grant applicant based on your status as a private nonprofit organization, verification of your incorporation number and current legal standing must be obtained from the *California Secretary of State Information Retrieval /Certification & Records Unit* (IRC Unit). The “Status Inquiry” document must be attached as an appendix to the application. To assist you in obtaining this information, use one of the following methods:

* To obtain Corporate Records Information over the Internet, go to <https://bizfileonline.sos.ca.gov/search/business> and enter your agency name. If you are active, print the page or screenshot for use as proof. If the verification of your status is not available at the time you submit your application, you must indicate the date on which you requested the verification and the estimated date it will be forwarded to OCTA.
* If you are unable to locate the information online, you can obtain the “Status Inquiry” document by making a written request to:

**California Secretary of State**

**Information Retrieval/Certification Unit (IRC)**

**1500 11th Street, 3rd Floor**

**Sacramento, CA 95814**

**(916) 653-6814**

Please **do not** attach articles of incorporation, bylaws or tax status documentation.   
*Attachment 9 included?  Yes  No*

## **Private Non-profit Information**

|  |  |
| --- | --- |
| Legal Name of Non-profit Applicant: |  |
| State of California Articles of Incorporation Number: |  |
| Date of Incorporation: |  |
| *Attachment 10 included?* | *Yes  No* |

## **Public Agency Certification**

To enhance mobility for seniors and individuals with disabilities, the EMSD grant program also offers local transportation funding opportunities to public agencies where no private non-profit organizations are readily available to provide the proposed service.

A public agency must certify that no non-profit organizations are readily available to provide the proposed service, by completing and signing the Public Agency Certification below. A public hearing is **required** as part of the application process and should be completed by the application due date of June 27, 2024. Further, please attach the following to your application:

* 1. Submit proof of a public hearing notice, a copy of the contact letter/notice sent to non-profit transportation providers informing them of the hearing and minutes or documentation that the hearing took place.
  2. *S*ubmit a resolution that no non-profit agencies are readily available to provide the proposed service.
  3. *C*omplete Public Agency Certification.
  4. Submit proof of contact with all non-profit transportation providers regarding notice of public hearing.

*Attachment 11 included?  Yes  No*

## **Certification of No Readily Available Service Providers**

|  |  |  |
| --- | --- | --- |
| The public agency, |  | , certifies that there are no non-profit |
| agencies readily available to provide the service proposed in this application. | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Certifying Representative: | | | |  | | |
| Title: |  | | | | | |
| Signature: | |  | | |  | |
| Date: |  |
| Date of Hearing: | | |  | | | |
| Attachment 12 provided? | | | *Yes  No  Formal Letter Attached as Alternative* | | | |

## **General Certifications and Assurances**

1. The use of grant-funded vehicles or grant-funded activities beyond the scope of an awarded project is prohibited. A deviation from the awarded project scope requires prior approval from OCTA.
2. Grantees shall follow competitive procurement practices in the purchase of vehicles and the selection of vendors for all services which it does not provide using its own workforce.
3. Any procurement of vehicles or services will specify the use of vehicles meeting Americans with Disabilities Act accessibility standards.
4. Grant-funded vehicles must provide a minimum of 10 hours of service per week per vehicle or in coordination with other agencies.
5. Grantees shall perform, or ensure that a contracted vendor performs proper maintenance of all vehicles, including, at a minimum:

a) Daily Pre-Operation Inspections.

b) Scheduled preventative maintenance that meets or exceeds manufacturer requirements, including the maintenance of all accessibility features of the vehicles.

c) Maintenance records for each vehicle shall be retained for 5 years.

1. Grantees cooperate fully in annual motor coach carrier terminal inspections conducted by the California Highway Patrol.
2. Grantees shall procure and maintain adequate insurance coverage during the term of the project and throughout the useful life of the vehicle. Coverage shall be full coverage or subject to self-insurance provisions.
3. Grantees shall ensure that its operators, or its contracted vendor’s operators, are properly licensed and trained to proficiently perform duties safely, and in a manner that treats its riders with respect and dignity. Disability awareness and passenger assistance will be included in this training.
4. Grantees shall ensure that it maintains adequate oversight and control over all aspects of services that are provided by a contracted vendor.
5. Grantees shall submit a quarterly report to OCTA’s Community Transportation Services, which includes, at a minimum, a monthly and fiscal year-to-date summary of service and expenditures. Additional reporting may be requested as needed.
6. Grantees shall participate in OCTA marketing and outreach efforts to encourage use of transit services by seniors and individuals with disabilities.
7. Grantees shall note OCTA sponsorship in any promotional material for service funded under this agreement and may be required to display OCTA program logo on vehicles used in this program (excluding taxis).
8. Grantees shall ensure compliance with all applicable provisions of Title VI of the Civil Rights Act, Americans with Disabilities Act, and promptly notify OCTA of any issues or complaints.
9. Non-compliance to program requirements may result in relinquishment of vehicles and/or equipment to OCTA.

## **Coordinated Plan Certification**

The projects selected for funding under the Orange County Enhanced Mobility for Seniors and Disabled (EMSD) grant program must be supported by the Coordinated Plan, which was developed through a process that includes representatives of public, private, and non-profit transportation and human services providers and participation by members of the Orange County community.

Orange County’s current Coordinated Plan was adopted by the Orange County Transportation Authority (OCTA) Board of Directors on November 23, 2020. The Coordinated Plan is available for download and review at[*https://www.octa.net/pdf/OCTA%20Coordination%20Plan.pdf*](https://www.octa.net/pdf/OCTA%20Coordination%20Plan.pdf)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **I certify that the project in this application is supported by *Human Services Transportation Coordination Plan for Orange County.*** | | | | | | |
| Agency (Applicant) Legal Name: | | |  | | | |
| Authorizing Agency Representative (Print): | | | |  | | |
| Title: |  | | | | | |
| Signature: | |  | | |  |  |
|  |  |
| Date: |  |

## **Application Certification**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Authorizing Representative must certify the information contained in this application is true and accurate and has signature authority to enter into grant agreements on behalf of the applicant organization.** | | | | |
| Authorizing Agency Representative (Print): | |  | | |
| Title: |  | | | |
| Signature: |  | |  |  |
|  |  |
| Date: |  |

1. Grants in this instance does not include this grant request. [↑](#footnote-ref-2)
2. **20% minimum for Operating Assistance and 10% for Mobility Management.** [↑](#footnote-ref-3)
3. **Up to 80% (for Operating Assistance) or 90% (for Mobility Management) of project cost or no greater than $1 million – funding request should consider indirect and contingency costs, not to exceed a combined $1 million.** [↑](#footnote-ref-4)
4. The maximum request amount per applicant for operating type projects is $1,000,000 for two years of service operations, that is either for mobility management or operating assistance or a combination of the two. The total maximum applicant request for capital and operating combined is $1.5 million. [↑](#footnote-ref-5)
5. Total project cost will include Local Match + Mobility Management and/or Operating Assistance Request(s) + Contingency Cost + Indirect Costs [↑](#footnote-ref-6)