|  |
| --- |
| Digital Communications ***Capital Grant Application*** ***for Vehicles and Related Equipment***  **Orange County Enhanced Mobility** **for Seniors & Disabled Grant Program** *Applications due to OCTA by 4:00 pm on September 9, 2021* |
| Please complete all sections of this application. Incomplete and/or missing information will not be considered for funding. Instructions and other guidance documents are available on OCTA’s website at [www.octa.net/emsd](file:///C%3A%5CUsers%5Cjfarinas%5CDesktop%5Cwww.octa.net%5Cemsd). Completed applications should not exceed 35 pages, excluding required attachments.   |
| Agency (Applicant) Legal Name: **\_\_\_\_** |
| Physical Address (No P.O. Box) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City \_\_\_\_ County \_\_\_\_ Zip \_\_\_\_ |
| Contact Person (Grant Management) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Alternate Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone \_\_\_\_ | E-Mail Address \_\_\_\_ |
| 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. Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ |
| Service Area (briefly indicate areas served by the proposed project, additional detail should be provided in the required map attachment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Upload application and supporting documents at [www.octa.net/emsd](http://www.octa.net/emsd) by September 9, 2021 at 4PM. **Late applications will not be accepted.** We recommend uploading your documents 48 hours prior to allow time for troubleshooting if needed. Hard copy applications will be accepted, see guidelines for instructions.   |

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**PART I –APPLICANT PROFILE**

**Agency Purpose & Program**

1. Briefly describe your agency’s purpose and program. **Include the 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 included? [ ]  Yes [ ]  No

Click here to enter text.

1. Describe the available non-profit, public transit or paratransit, including fixed route, ADA complementary paratransit services. This is an assessment of available services that identifies current transportation providers (public, private, and non-profit).

Click here to enter text.

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.**

Click here to enter text.

**Agency Geographic Area**

Please attach an 8-1/2 x 11 map delineating service boundaries to the application.

**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 most closely describes 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 \_\_\_\_\_\_\_ Number of individuals w/disabilities \_\_\_\_\_\_\_ Number of wheelchair/lift users \_\_\_\_\_\_\_ **Total number of clients** \_\_\_\_\_\_\_  | American Indian & Alaska Native \_\_\_\_\_\_\_%Asian \_\_\_\_\_\_\_%Black or African American \_\_\_\_\_\_\_%Hispanic or Latino \_\_\_\_\_\_\_%Native Hawaiian & Pacific Islander \_\_\_\_\_\_\_% All Other \_\_\_\_\_\_\_% |
|  Total number of wheelchair/lift users  divided by clients \_\_\_\_\_\_\_% |
|  | **Total must be 100%** \_\_\_\_\_\_\_% |

# **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.

## **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 continuance of service. (Examples: service at capacity service parameters, routes, hours, need not met due to eligibility and/or trip criteria, projected future need, vehicles inaccessible, etc.)

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

1. **Existing Transit Service**

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.

Click here to enter text.

**Proposed Budget for Transportation Program**

1. ***Annual Operating Budget*** :

|  |  |
| --- | --- |
| **Estimated Income** |  |
| 1. Passenger Revenue
 | $\_\_\_\_\_\_\_\_ |
| 1. Other Revenues
 | $\_\_\_\_\_\_\_\_ |
| 1. Total grants\*, donations, subsidies from other agency funds
 | $\_\_\_\_\_\_\_\_ |
| **TOTAL INCOME** | **$\_\_\_\_\_\_\_\_** |
|  ***\*****Not including this grant request.* |  |
| **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) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | $\_\_\_\_\_\_\_\_ |
| **TOTAL EXPENSES** | **$\_\_\_\_\_\_\_\_** |

1. ***Operating* *Fund Sources***

|  |  |  |  |
| --- | --- | --- | --- |
| **Operating Fund Sources** | **Prior Year** | **Current Year** | **Next Year** |
| 1. \_\_\_\_\_\_\_\_
 |  | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_
 |  | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_
 |  | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_
 |  | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_ |
| **TOTAL OPERATING** |  | **$\_\_\_\_\_\_\_\_** |

1. ***Local Match Source***

|  |  |
| --- | --- |
| **Local Match Sources** |  **AMOUNTS** |
| 1. \_\_\_\_\_\_\_\_
 | $\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_
 | $\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_
 | $\_\_\_\_\_\_\_\_ |
| **TOTAL LOCAL MATCH** (10% of Total Project Cost) | **$\_\_\_\_\_\_\_\_** |

**PART II – FUNDING REQUEST**

**Vehicle Request**

Estimated costs are used to determine the funding amount granted for each capital project, which includes vehicles and other equipment. Awards are made for the procurement of the specific project, not for a guaranteed amount of funds. The EMSD grant funds are provided on a reimbursement basis, with the exception of vehicles greater than $100,000 where OCTA will provide 65% of the award amount up front. Reimbursements are based on actual project costs, not to exceed the grant award. See page 9 of the guidelines for more information. Use space below to provide answers for this section.

If requesting an alternative fuel vehicle, please provide details about whether your organization has the requisite fuel infrastructure or fueling station within close proximity.

Click here to enter text.

**Complete for vehicle(s) requested.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Vehicle Purchase** | **Quantity Request** | **Estimated Unit Cost\*\*** | **Total Cost** |
| **Vehicles**  |  |  |  |
| Minivan 5 Ambulatory Passengers (AP) includes ramp |  \_\_\_\_ | $55,000 | \_\_\_\_\_\_\_ |
| Small Bus (Ford or GM) 8 AP; 2 Wheelchair (WC)\* |  \_\_\_\_  | $78,000 | \_\_\_\_\_\_\_ |
| Medium Bus (Ford or GM) 12 AP; 2 WC\* |  \_\_\_\_ | $79,000 | \_\_\_\_\_\_\_ |
| Medium Bus 12 AP; 2 WC,\* Compressed Natural Gas\*\*\* |  \_\_\_\_ | $112,000 | \_\_\_\_\_\_\_ |
| Large Bus 16 AP; 2 WC\* |  \_\_\_\_ | $86,000 | \_\_\_\_\_\_\_ |
| Large Bus 16 AP; 2 WC,\* Compressed Natural Gas\*\*\* |  \_\_\_\_ | $115,000 | \_\_\_\_\_\_\_ |
| Larger Bus (Ford or International) 20 AP; 2 WC\* |  \_\_\_\_ |  $124,000 | \_\_\_\_\_\_\_ |
| Other^ |  \_\_\_\_ | $0 | $0 |

\* Rear wheelchair lift floor plan.

\*\*Unit costs are an estimated cost of vehicle, equipment and related charges and are subject to change at the time of purchase.

\*\*\*Justify the need for an alternative fuel vehicle if requested. Indicate whether your agency has the requisite fuel infrastructure, as well as the proximity of the fuel station in relation to your agency.

^ Please use the other category for vehicle requests that are not listed, such as zero-emission vehicles.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vehicle Lease** | **Quantity Request** | **Lease Term (months)** | **Estimated Unit Cost Per Month** | **Total Cost Over Lease Term\*** |
| **Vehicles**  |  |  |  |  |
| Minivan 5 Ambulatory Passengers (AP) includes ramp |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |
| Small Bus (Ford or GM) 8 AP; 2 Wheelchair (WC)\* |  \_\_\_\_  |  |  | \_\_\_\_\_\_\_ |
| Medium Bus (Ford or GM) 12 AP; 2 WC\* |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |
| Medium Bus 12 AP; 2 WC,\* Compressed Natural Gas\*\*\* |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |
| Large Bus 16 AP; 2 WC\* |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |
| Large Bus 16 AP; 2 WC,\* Compressed Natural Gas\*\*\* |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |
| Larger Bus (Ford or International) 20 AP; 2 WC\* |  \_\_\_\_ |  |  | \_\_\_\_\_\_\_ |

\*Applicants should include tax, title fee, acquisition fees, etc. to provide the total cost of the vehicle over the lease term.

For leased vehicles, please attach a cost benefit analysis showing that leasing the vehicle is the same cost or better. Attachment included? [ ]  Yes [ ]  No [ ]  N/A

**Request for Other Equipment**

Other eligible equipment includes computer hardware and software (including scheduling and vehicle maintenance software), transit-related intelligent transportation systems, radios and communication equipment, wheelchair restraints, and initial component installation costs.

For the 2021 Call, this category also includes COVID-19 Response Equipment. COVID-19 Response equipment includes personal protective equipment such as gloves, face masks, and sanitation equipment in addition to the installation of plexiglass shields.

Applicant must attach three quotes of like-kind equipment **with** this application. The quotes must describe the salient characteristics of the equipment and the characteristics must be consistent across all quotes. These quotes will serve as an Independent Cost Estimate (ICE), and the average of the three quotes will be the requested grant amount. Use the chart below to summarize the three quotes and attach vendor quotes. Attachment included? [ ]  Yes [ ]  No

**Complete for other equipment requested**

Note: The minimum grant amount for equipment is $1,000 and is not to exceed $50,000.

|  |
| --- |
| **Computer Equipment or Other Equipment Requests** |
| **Equipment Type** | **Description** | **Quantity** | **Unit Cost** | **Total** |
| Computer Hardware  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Computer Software | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Other Equipment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Other Equipment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| **Communications Equipment Requests** |
| Base Station | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Mobile Radio(s) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Other Equipment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| Other Equipment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
| **TOTAL (cannot exceed $50,000)** | **\_\_\_\_\_\_\_** |

|  |  |
| --- | --- |
| **TOTAL PROJECT COST** (Vehicles and Other Equipment) | **\_\_\_\_\_\_\_** |

\*If also requesting funding for EMSD Operating category, the total of both applications (Capital and Operating) shall not exceed $600,000 to ensure a more equitable distribution of funds.

**Agency Inventory (Required for ALL other equipment requests)**

1. Complete table for the requested other equipment, expand this table if necessary:
	1. Indicate equipment type to be replaced.
	2. Indicate the quantity of existing equipment units by like kind.
	3. Indicate the age of the equipment.
	4. Indicate the requested number of units of additional equipment.
	5. Indicate the total number of vehicles in your transportation fleet.

|  |  |  |  |
| --- | --- | --- | --- |
| **Equipment Type to be replaced** | **Quantity/Purchase Date of Existing Equipment within Agency**  | **Quantity of****Requested Equipment** | **Current Fleet Size** |
| Example: Computer | 324 | 5-18-20051-1-20016-15-2004 | 6 | 10 |
| Example: Mobile Radios | 83 | 8-14-20074-21-2002 | 4 | 15 |
| Example: Software | 0 | - | 1 | 16 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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**Replacement Vehicles** (Maintaining existing service levels)

To be eligible for replacement, the vehicle **must currently be registered to the applicant**, have a **wheelchair accessible** ramp or lift, and must be **in active service.** Leased vehicles, sedans and SUVs are **not eligible** for replacement. Applications for vehicle replacements **must be like-kind.**  For example, if an application request is for a small replacement bus, the vehicle to be replaced must be a small bus.

A **photograph** of the vehicle(s) proposed for replacement **must be attached**. Please take a photograph at an angle to show back wheels, along with a photo of the license plate and VINs.

Attachment included? [ ]  Yes [ ]  No

Explain why the vehicle(s) need to be replaced in order to maintain existing service levels or ensure the continuance of existing services. Describe the service the vehicle(s) will provide and the service area.

Click here to enter text.

**New Service or Service Expansion Vehicles**

Explainthe new service or growth your agency is experiencing, the projected increase in the number of clients you will serve, and the basis for your estimates. Describe the service area, the type of service the vehicle(s) you are requesting will provide and how it relates to the needs assessment in the Coordinated Plan.

Related Documentation supporting this growth **must be attached** as an appendix and its relevance discussed within the narrative (e.g., current waiting list, reports of trips denied).

Attachment included? [ ]  Yes [ ]  No

Projected number of **one-way passenger trips per day** to be provided by each vehicle: \_\_\_\_

Click here to enter text.

2. Describe the type of equipment you are requesting and identify the specific components.

Click here to enter text.

3. Discuss how the requested equipment will be used to support the transportation program. Include any expected improvements in service delivery or coordination, any reduction in the cost of providing service, and the current method of collecting and tracking information.

Click here to enter text.

**PART III – SCORED QUESTIONS**

1. **Goals and Objectives (10 points)**
2. Please describe how the project is consistent with the overall goals of the EMSD program. (10 points)

Click here to enter text.

1. Explain how the project increases or enhances the availability of transportation of the targeted population (4 points).

Click here to enter text.

1. Explain how the project meets the program requirement of providing transportation related activities and/or services beyond those required by the Americans with Disabilities Act (ADA) (2 points).

Click here to enter text.

**B. Ability of Applicant (20 points)**

1. Describe your organization’s experience and history in providing efficient and effective transit services. Please state how many years your organization has provided services to seniors and individuals with disabilities. If you will be a first-time provider of transportation services, provide the number of years you have provided social services to seniors and individuals with disabilities.

Click here to enter text.

1. Describe your agency’s **driver training program** by specifically discussing each of the following components indicating whether they will be performed in-house or under contract and the staff or position(s) responsible (up to 4 points):
* New Driver Orientation and Training; including classroom and behind the wheel and testing. Including ongoing training.
* Sensitivity Training, Emergency Preparedness, First Aid and CPR.

Attachments included? [ ]  Yes [ ]  No

Click here to enter text.

1. Describe your agency’s **system for dispatching vehicles** and discuss training of staff in the dispatching function. (2 points) Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. Describe your agency’s **vehicle maintenance program**, addressing **each** of the following components. In describing the items specified below, attach pre-trip **and** post-trip inspection forms and maintenance forms as an appendix (up to 6 points).
* Daily pre-trip and post-trip inspection description with daily inspection forms
* Preventative & routine maintenance description, with maintenance forms
* Contingency plan for when equipment is not available for service

Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. If your agency operates vehicles with more than 10 passengers (includes driver), attach a copy of your most recent CHP vehicle and terminal inspection report. If your agency is not required to have a CHP inspection attach your agency’s most current vehicle inspection reports. This information must match the Existing Transportation Services Table on page 21 of this application. (2 points) Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. What grants or other funding strategies have you pursued to meet the needs of this project? (2 points)

Click here to enter text.

**C. Coordination Planning**(12 points)

To help meet the mobility needs of seniors and individuals with disabilities in Orange County, the EMSD grant program is intended to make local funds available to projects that are consistent with the goals and needs outlined in the OCTA’s Human Services Transportation Coordination Plan (Coordinated Plan). The following four questions address how this proposed project is supported by the Coordinated Plan for Orange County, which is available at <http://www.octa.net/pdf/HumanServicesTransportation.pdf>

1. Please identify current transportation providers (public, private, and non‐profit) that provide service within your proposed service area and identify the relevant section/page number of the Coordinated Plan (3 points).

Click here to enter text.

1. Please describe the transportation needs of your senior and disabled clients to be served by the proposed project and identify the relevant section/page number of the Coordinated Plan (3 points).

Click here to enter text.

1. How does your agency identify coordination strategy activities and/or efficiencies and how does this project address them? Please identify the relevant section/page number of the Coordinated Plan. (3 points)

Click here to enter text.

1. How does this project(s) address one or more of the implementation priorities identified in Orange County’s Coordinated Plan?(3 points)

Coordinated Plan section and page number identified? [ ]  Yes [ ]  No

Click here to enter text.

*Coordination & Use of Vehicles/ Equipment* (5 bonus points)

OCTA encourages the maximum use of vehicles funded by the EMSD grant program and supports the coordination of vehicles and other transportation related activities where opportunities exist. Examples of the coordination of services include:

1. Dispatching or scheduling
2. Maintenance
3. Back-up transportation
4. Staff training programs
5. Procurement of services and supplies from other funding sources
6. Active participation in local social service transportation planning process

To obtain up to 5 bonus points for questions 5 & 6 below**, a letter(s) must be attached** from the agency with which you are coordinating services to substantiate the coordination activities.

1. Describe how vehicles in agency’s **existing** fleet, services, or equipment, are used to provide coordinated service for another agency’s clients or how these vehicles are shared with another agency(s). (Up to 2 bonus points) **Narrative must include**:
* The name of the participating agency(s)
* Agency description, and usage of vehicle(s)
* Days and hours of use
* Number of passengers using service

Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. Describe your plan for coordinating the use of the **requested** vehicle(s) or equipment. (Up to 3 bonus points) **Narrative must include**:
* Name of the participating agency(s)
* Agency description, and usage of vehicle(s)
* Days and hours of use
* Number of passengers using service

Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. If you are unable to coordinate, explain why. Discuss any attempts the agency has made to coordinate. Provide supporting documentation.

Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. **Outreach and Feedback** (10 points)

Please attach up to three support letters from stakeholders.

1. What outreach did you do within your client group to confirm the current need for the project? (4 points)

Click here to enter text.

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. (3 points)

Click here to enter text.

1. Describe strategies for sustaining this program beyond the two-year funding cycle. (3 points)

Click here to enter text.

**E. Transportation Service** (32 points plus 5 bonus points)

***1. Bonus Question:*** Is your agency partnering with another provider to create efficiencies and lower operating costs for service and/or increase vehicle revenue hours beyond the minimum 10 hours? If yes, please provide documentation of the partnership. Attachment(s) included? [ ]  Yes [ ]  No

Up to 5 additional bonus points will be awarded for partnerships that create efficiencies in lowering operating costs as follows: 11-12 hours – 1 bonus point, 13-14 hours – 2 bonus points, 15-16 hours – 3 bonus points, 17-18 hours – 4 bonus points, 19+ hours – 5 bonus points

Click here to enter text.

# **PART III - SCORING CRITERIA (continued)**

**Existing Transportation Services (20 point maximum)**

To complete the chart below, list all vehicles your agency currently owns or leases that provide passenger service to seniors and/or individuals with disabilities. Include backup vehicles and those to be removed from service if a new vehicle is awarded. **Also list any vehicles you have on order or for which you have received a grant or commitment from any source (e.g., Section 5310, Department of Aging, city or county.)**

**For replacement vehicle requests**: Replacement vehicles are identified as those needing replacement in order for the Agency to continue their existing services. For each new vehicle requested, a current vehicle in active service **must** be placed in backup or sold.

**Answer the following questions and complete the chart below.**  See Application Instructions for information regarding each column entry.

1. Total miles traveled per day for all active vehicles in fleet (**excluding the vehicles indicated as backup in Column 7**) ­­­­\_\_\_\_\_\_\_.
2. Days of Service (e.g., Monday thru Sunday) \_\_\_\_\_\_\_.
3. Percentage of current wheelchair/lift users \_\_\_\_\_\_%
	1. To compute, divide total riders (Applicant Profile Table, Page 4) by wheelchair/lift clients.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **\*1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **\*10** | **\*11** | **12** |
|  | **List All VINs in Fleet****(Last 5 digits)** | **Replacement Requests** **Vehicle Type** **/Disposition** | **List All Active Vehicles by****Year/Make** | **Current Mileage** | **Passenger****Capacity****Ambulatory/****Wheelchair** | **Number of Fold Down Seats** | **Current Backup****Vehicle****Y/N** | **Date Purchased or Leased (indicate if leased)** | **Registered****Owner (not lienholder)** | **Vehicle Service Hours Per** **Day** | **Total One Way Passenger Trips Per Day** | **12 Month Maintenance****&****Repair Costs** |
| ***Ex*** | ***12345*** | ***Van/BK*** | ***2003 Ford*** | ***252,899*** | ***6A/2W*** | ***3*** | ***N*** | ***1-1-01*** | ***Agency X*** | ***6*** | ***16*** | ***$1,000*** |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |  |
|  9 |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | **Total for Columns 10 & 11** |  |  |  |

**Proposed Transportation Services (15 point maximum)**

**New or Service Expansion**: This table is to be completed by agencies (starting a new transportation service or adding new or additional service to their current program. See instructions for information on how to fill out the chart.

**Complete following question and the chart below:**

1. **Compute the total percentage of current and projected wheelchair/lift users \_\_\_\_\_%**

For Expanded Service: Use the total number of wheelchair/lift users in your current program (page 3 of this application), add the projected number of lift users for this expanded service, then divide by the total number of existing and projected passengers from column 6 below.

For New Service: Use the total number of projected wheelchair/lift users then divide by total projected passengers from column 6 below.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|  | **Type of Request****N – New agency** **SE – Service Expansion** | **Vehicle Type** | **Days of Service** | **Total Service Hours Per Day** | **Total Service Hours Per Week** | **Total one way passenger Trips Per Day (number of lift users)** | **Projected Mileage Per Day** |
| ***Ex*** | ***N or SE*** | ***Small Bus*** | ***5*** | ***6*** | ***30*** | ***25(5)*** | ***400*** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |

**Other Equipment**

Other Equipment: Computer system, software and or communication. For the 2021 Call, this category also includes COVID-19 Response Equipment.

If you are making a request for new equipment based on the inadequacy of your old equipment, please include a detailed description of the make and year model of the equipment to be replaced consistent with the scoring worksheet. The equipment must be used to support your transportation operation, that is, the number of vehicles you operate in your transportation program.

|  |  |
| --- | --- |
| * 1. How many vehicles are in the existing Service Fleet (including back up)? (Maximum 15 pts)
 | **\_\_\_\_** |
|  |  |
| * 1. Is the applicant currently using a manual system for scheduling, vehicle tracking, etc. and/or has no dispatch communication equipment? (5 points)
 | **\_\_\_\_** |
| OR |
| * 1. Does the applicant need to replace inadequate equipment to improve efficiency? (reference equipment request tables above)

Equipment more than 5 years old – 5 pts3 to 5 years old – 3 ptsLess than 3 years old – 0 pts | **\_\_\_\_** |
|  | Total (Maximum 20 Points) | **\_\_\_\_** |

1. Fleet utilization determination
2. What are the total service hours per week for your existing or projected fleet? \_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is the existing or projected number of passengers per hour? \_\_\_\_\_\_\_\_\_\_\_
4. What are the total vehicle miles per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**F. Emergency Planning and Preparedness (10 points)**

1. Vehicle Information: Describe the steps you have taken with the County Office of Emergency Services to identify available accessible vehicles for potential use during an emergency (5 points)

Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

1. Agency Information: Describe the **emergency planning and drill activities** within your agency and in cooperation with the county. Provide proof your agency is included in the response plan with the County Office of Emergency Services. Indicate the drill(s) you have participated in, or are scheduled to participate in. (5 points) Attachment(s) included? [ ]  Yes [ ]  No

Click here to enter text.

**PART IV – CERTIFICATIONS**

# **Private Nonprofit 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://businesssearch.sos.ca.gov/> 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.

**Private Nonprofit Information**

|  |
| --- |
| Legal Name of Non-profit Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| State of California Articles of Incorporation Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Incorporation: \_\_\_\_\_\_\_\_ |
| Attachment 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 September 9, 2021. 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.

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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(s) included? [ ]  Yes [ ]  No

Click here to enter text.

**Title VI & ADA Requirements & 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.

Click here to enter text.

**General Certifications & 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\_\_\_\_ |