|  |  |
| --- | --- |
| **Complete Application Checklist for CAPITAL Projects**  ***All Attachment files should be clearly named prior to upload.*** | |
| **✓** | **Application Narrative Responses** |
|  | **General Information** |
| **Part I –** **A****pplicant Profile** | |
|  | **Agency Information** |
|  | **Agency Geographic Area** |
|  | **Applicant Profile** |
|  | **Audited Financial Statement** |
|  | **Title VI and ADA Requirements and Complaints** |
|  | **Project Need** |
| **Part II – Funding Request** | |
|  | **Application Funding Request Summary** |
|  | **Proposed Local Match Source for Capital Requests** |
|  | **Requested Programming Year** |
|  | **Detailed Vehicle Acquisition Request** |
|  | **Vehicle Request Supplemental Questions** |
|  | **Detailed Equipment Request** |
|  | **Equipment Request Supplemental Questions** |
|  | **Agency Inventory** |
| **Part III – Scored Questions** | |
|  | 1. **Goals and Objectives** |
|  | 1. **Ability of Applicant** |
|  | 1. **Coordination Planning** |
|  | 1. **Outreach and Feedback** |
|  | 1. **Transportation Services** |
|  | 1. **Emergency Planning and Preparedness** |
| **Part IV – Certifications** | |
|  | **Private Non-profit** **Agency – Corporation** **Status Inquiry** |
|  | **Public Agency** **Certification** |
|  | **Certification of No Readily Available Service Providers** |
|  | **General Certifications and Assurances** |
|  | **Coordinated Plan Certification** |
|  | **Application Certification** |
| **Attachments – Optional, 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: Vehicle Cost-Benefit Analysis |
|  | Attachment 6: New Service or Service Expansion Supporting Documentation |
|  | Attachment 7: Vehicle(s) Proposed for Replacement Photographs |
|  | Attachment 8: Equipment Quotes |
|  | Attachment 9: Transit Experience Supporting Documentation |
|  | Attachment 10: Driver Training Supporting Documentation |
|  | Attachment 11: Vehicle Maintenance Program Supporting Documentation |
|  | Attachment 12: CHP Vehicle and Terminal Inspection Report |
|  | Attachment 13: Partnership Documentation |
|  | Attachment 14: Existing Transportation-Related Service(s) – Vehicles |
|  | Attachment 15: Existing Transportation-Related Service(s) – Equipment |
|  | Attachment 16: Proposed Transportation Service(s) – Vehicles and Equipment |
|  | Attachment 17: County Office of Emergency Services Accessible Vehicle Documentation |
|  | Attachment 18: Emergency Planning and Preparedness Policies and Procedures Documentation |
|  | Attachment 19: Private Non-profit Agency – Corporation Status Inquiry Documentation |
|  | Attachment 20: Private Non-profit Information |
|  | Attachment 21: Proof of a Public Hearing Notice or Formal Letter Certification |
|  | Attachment 22: Certification of No Readily Available Service Providers Documentation |
|  | Attachment 23: Letters of Support |
|  | Attachment 24: |

# **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* | **CAPITAL** | | | |
| Project Title: |  | | | |
| Phase of Work that request would support (Vehicle Request, Request for Other Equipment, Replacement Vehicles, New Service or Expansion, etc.) Be sure to include a brief description for each item: |  | | | |
| Brief Project Description – Include a list of requested items, if requesting multiple items under the same application please fully list out each item and quantity: |  | | | |
| 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 service.* ***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*

|  |  |
| --- | --- |
| **Days/Hours of Operation:** |  |
| **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%** | |  | **%** |

## **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 Individuals with Disabilities (EMSD) 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, in reference to the prior selection above.*

|  |
| --- |
| **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**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Project Component** | **Total Project Cost**  **(Request + Match)** | | **Match** | | **Match %**  **(10% minimum)** | | **Funding Request[[1]](#footnote-2)  (Total - Match)** | | **Staff Cost  (10% maximum)** | | **Contingency  (5-10%)** | |
| **Vehicles** | $ |  | $ |  |  | % | $ |  | $ |  | $ |  |
| **Equipment** | $ |  | $ |  |  | % | $ |  | $ |  | $ |  |
| **TOTAL** | **$** |  | **$** |  |  | | **$** |  | **$** |  | **$** |  |
| Please note that the total funding request **per applicant** may not exceed $1.5 million. | | | | | | | | | | | | |

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

|  |  |  |
| --- | --- | --- |
| **Project Component** | **Local Match Amount**  **(consistent with previous table)** | **Local Match Source(s)** |
| **Vehicle Acquisition** |  |  |
| **Equipment** |  |  |

## **Requested Programming Year**

|  |  |  |
| --- | --- | --- |
| Indicate in which Fiscal Year (FY) funding is planned to be requested. Funds may be requested for FY2024/25, 2025/26, or 2026/27 **ONLY** (FYs ending June 30). See Timely-Use of Funds Section of guidelines for more information. | | |
| Vehicle Acquisition Programing FY Request: | FY |  |
| Equipment Programming FY Request: | FY |  |

## **Detailed** **Vehicle Acquisition Request**

Estimated costs determine the funding amount granted for each capital project, including vehicles and other equipment. Awards are made for the procurement of the specific project, not for a guaranteed amount of funds. EMSD grant funds are provided on a reimbursement basis, with the exception of vehicles where OCTA will provide 65% of the award amount up front. Reimbursements are based on actual project costs, not to exceed the award.

**Vehicle Request Type – Please select one. ✓**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | New Vehicles |  | Used Vehicles |  | Leased Vehicles |

**Complete for Vehicle(s) Requested**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Vehicle Purchase (New or Used)[[2]](#footnote-3)** | | **Quantity** | **Estimated Unit Cost[[3]](#footnote-4)** | | **Total Cost (Quantity x Unit)** | |
| Minivan | |  | $ |  | $ |  |
| Small Bus | |  | $ |  | $ |  |
| Medium Bus | |  | $ |  | $ |  |
| Medium Bus – Compressed Natural Gas (CNG) | |  | $ |  | $ |  |
| Large Bus | |  | $ |  | $ |  |
| Large Bus – CNG | |  | $ |  | $ |  |
| Larger Bus | |  | $ |  | $ |  |
| ZEV/ZEB: |  |  | $ |  | $ |  |
| Other: |  |  | $ |  | $ |  |
| Contingency Line Item (to account for changes due to cost increases, project delays, etc..) 5-10% | | | | | $ |  |
| **TOTAL** | | | | | **$** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vehicle Lease** | | **Quantity** | **Lease Term (months)** | **Estimated Unit Cost Per Month** | | **Total Cost Over Lease Term[[4]](#footnote-5)** | |
| Minivan | |  |  | $ |  | $ |  |
| Small Bus | |  |  | $ |  | $ |  |
| Medium Bus | |  |  | $ |  | $ |  |
| Medium Bus – CNG | |  |  | $ |  | $ |  |
| Large Bus | |  |  | $ |  | $ |  |
| Large Bus – CNG | |  |  | $ |  | $ |  |
| Larger Bus | |  |  | $ |  | $ |  |
| ZEV/ZEB: |  |  |  | $ |  | $ |  |
| Other: |  |  |  | $ |  | $ |  |
| Contingency Line Item (to account for changes due to cost increases, project delays, etc..) 5-10% | | | | | | $ |  |
| **TOTAL** | | | | | | **$** |  |

h

**Vehicle Acquisition Cost Effectiveness Requirement**

If request is for purchase of *used vehicles* or for the *lease* of vehicles, a cost-benefit analysis must be provided which clearly indicates that the selected option for vehicle acquisition is more cost-effective compared to the purchase of new vehicles. *Attachment 5 included?  Yes  No  N/A*

## **Vehicle Request Supplemental Questions**

*Please briefly describe how costs for vehicle acquisition were estimated.*

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

*If requesting zero-emission vehicle(s) (ZEV), please provide details about whether your organization has the necessary fuel infrastructure or fueling station within close proximity. If requesting used vehicle(s), please provide details about your agency’s reasoning for doing so.*

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

*Please provide goals for trips and miles traveled annually for the vehicles requested:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Vehicle Type** | **Quantity** | **Annual Goal for One-Way Passenger Trips** | **Annual Goal for Miles Traveled** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**New Service or Service Expansion Vehicles**

1. 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 Orange County Human Servicers Transportation Coordination Plan (Coordinated Plan).

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

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 6 included?  Yes  No*

**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 are **only eligible** for replacement if the vehicle was funded through the previous EMSD call in 2021. 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(s)** of the vehicle(s) proposed for replacement **must be attached**. Please take photographs at an angle to show the back wheels, along with a photo of the license plate and VINs. *Attachment 7 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.

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

## **Detailed Equipment Request**

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.

Applicants must attach at least one quote of like-kind equipment **with** this application. Multiple quotes are preferred. The quotes must describe the salient characteristics of the equipment and the characteristics must be consistent across all quotes provided. These quotes will serve as an Independent Cost Estimate (ICE), and the lowest of the quotes provided will be the requested grant amount. Use the chart below to summarize the quotes provided and attach vendor quotes. *Attachment 8 included?  Yes  No*

**Complete for Other Equipment Requested**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 |  |  | $ |  | $ |  |
| Contingency Line Item (to account for changes due to cost increases, project delays, etc..) 5-10% | | | | | $ |  |
| **TOTAL** | | | | | **$** |  |

|  |  |  |
| --- | --- | --- |
| **Optional – Staff Salaries (Indicate if associated with vehicles or equipment)** | **Cost** | |
|  | $ |  |
|  | $ |  |
|  | $ |  |
| **Staffing Cost (No greater than 10% of total project cost)** | **$** |  |

|  |  |  |
| --- | --- | --- |
| **TOTAL COST OF PROJECT[[5]](#footnote-6)** | **$** |  |

If also requesting funding for EMSD Operating category, the total of both applications (Capital and Operating) shall not exceed $1,500,000 to ensure a more equitable distribution of funds. The total amount for this application type cannot exceed $1,000,000. Segmented Capital applications containing ZEVs and motor vehicles must also not exceed this amount.

## **Equipment Request Supplemental Questions**

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

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

1. 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.

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

1. Describe a proposed timeline of when new services or service expansions may go into effect. Discuss a time frame for the purchasing of vehicles and/or equipment based on the FY requesting funds to be programmed in.

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

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

1. Complete the table on the following page for the requested other equipment, expand this table if necessary:
   1. Indicate equipment type to be replaced and quantity of existing equipment by like kind.
   2. Indicate the age of the equipment and requested number of units of additional equipment.
   3. 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 | 3  2 | 05/18/2005  01/10/2001 | 6 | 10 |
| Example: Mobile Radios | 8 | 08/14/2007 | 4 | 8 |
| Example: Software | 0 | - | 1 | - |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# **Part III – Scored Questions**

## **Goals and Objectives** **(6 Points)**

1. Describe how the project is consistent with the overall goals of the EMSD program. How does the project increase or enhance the availability of transportation of the targeted population.

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

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

1. Explain how the project meets the program requirement of providing transportation related activities and/or services beyond those required by the ADA. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)

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

## **Ability of Applicant (10 Points)**

1. Describe your organization's transit experience, including years serving seniors and individuals with disabilities. If a first-time transit provider, state years providing social services. Detail your agency’s vehicle dispatch system, staff training, and discuss relevant project grants or funding. (4 Points – 4-High, 3-Medium-High, 2-Medium-Low, 1-Low)

*Attachment 9 included?  Yes  No*

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

1. Describe your agency’s **driver training program**, specifying **each** component, indicating whether they will be performed in-house or under contract, and the staff or position(s) responsible, including: new driver orientation and training; including classroom, behind the wheel, testing, and ongoing training, sensitivity training, emergency preparedness, first aid, and CPR. (2 Points – 2-Appropriate, 1-Adequate, 0-Inadequate)

*Attachment 10 included?  Yes  No*

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

1. Describe your agency’s **vehicle maintenance program**, specifying **each** component. In describing the items specified, attach pre-trip **and** post-trip inspection forms and maintenance forms as an appendix including: daily pre-trip and post-trip inspection description with forms, preventative and routine maintenance description with forms, and contingency plan for when equipment is not available for service. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate) *Attachment 11 included?  Yes  No*

Top of Form

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

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. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)   
   *Attachment 12 included?  Yes  No*

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

## **Coordination Planning (6 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.   
   (4 Points – 4-High, 3-Medium-High, 2-Medium-Low, 1-Low)

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

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. How has this project(s) addressed one or more of the implementation priorities in the Coordinated Plan? Additionally, discuss how coordination planning is conducted between yours and other agencies. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)   
   *Coordinated Plan section and page number identified?  Yes  No*

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

## **Outreach and Feedback (5 Points)**

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

(2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)

|  |
| --- |
| **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. (3 Points –3-High, 2-Medium, 1-Low)

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

## **Transportation Services (18 Points)**

1. Is your agency partnering with another service provider to create efficiency and lower operating costs for service and/or increased vehicle revenue hours? Provide documentation of the partnership(s) and discuss efficiencies that have been created. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)

*Attachment 13 included?  Yes  No*

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

1. Describe your agency’s existing transportation-related service(s), discuss the types of vehicles and number of vehicles your agency currently owns or leases (include milage, vehicle age, yearly maintenance and repair costs, and any other relevant information). Provide an explanation for the type of transportation service(s) that are provided – what percentage of your clients require wheelchairs/lifts. How many miles per day do your vehicles travel, how many days a week, and at what hours they operate? Include all of your vehicles in the table below your response, add to the table as needed. (5 Points – 5-High, 4-Medium-High, 3-Medium, 2-Medium-Low, 1-Low)

*Attachment 14 included?  Yes  No*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Type response here.** | | | | | | | |
| **Current Fleet Information** | | | | | | | |
|  | **Model/Make (+ VIN)** | **Milage** | **Purchase or Lease Date** | **12-Month Maintenance Costs** | **Service Hours / Day** | **Service Days / Week** | **Total Miles Traveled / Service Day** |
|  |  |  |  |  |  |  |  |

1. Describe your agency’s existing transportation-related service(s) equipment. Include discussion and provide evidence on how it is used to support transportation-related services. What level of frequency is the equipment used? Is your agency currently using a manual system for scheduling, vehicle tracking, etc. Does your agency utilize a dispatch communication system/equipment? (4 Points – 4-High, 3-Medium-High, 2-Medium-Low, 1-Low)

*Attachment 15 included?  Yes  No*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type response here.** | | | | | | |
| **Current Equipment Information** | | | | | | |
| Is your agency currently using a manual system for services (i.e., scheduling, vehicle tracking, etc..)? | | | | | | *Yes  No* |
| Does your agency need to replace inadequate equipment due to age to improve efficiency? | | | | | | *Yes  No* |
| Equipment is: more than 5 years old |  | 3 to 5 years old |  | Less than 3 years old |  |

1. With this capital request for vehicles and/or equipment what are the proposed transportation service(s) that will be directly tied to the request. Describe any new and or service expansions that will come from the addition of new or replacement vehicles and include reasoning for the new vehicles (i.e., increase in clients, projections, etc..) or replacement of vehicles (i.e., reaching useful life, costly maintenance/repairs, etc..).

For related new or replacement equipment describe how they will be used and what purposes they will have for existing, new, or service expansions. Discuss what future projections for your agency look like with the number of clients and services. Include all of your vehicle and/or equipment request in the table below your response, add to the table as needed. (5 Points – 5-High, 4-Medium-High, 3-Medium, 2-Medium-Low, 1-Low)

|  |  |
| --- | --- |
| *Attachment 16 included?  Yes  No* | *Separate vehicle and equipment discussion.* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Type response here.** | | | |
| **Proposed Transportation Services** | | | |
| **Vehicles and/or Equipment Request(s) –** Add to table as needed | | | |
|  | **Vehicle or Equipment Request Type** | **Indicate if New, Continuation, Service Expansion, or Replacement Vehicle and/or equipment** | **Indicate the Vehicle’s and/or Equipment’s Useful Life** |
| **1** |  |  |  |

1. Describe strategies for sustaining this program beyond the two-year funding cycle. This involves outlining strategies for securing alternative funding, developing partnerships, and implementing sustainable practices to ensure the long-term viability and impact of each type of service. (2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate)

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

## **Emergency Planning and Preparedness (5 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. (3 Points – 3-High, 2-Medium, 1-Low)  
   *Attachment 17 included?  Yes  No*

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

1. Describe what policies and procedures your agency has in place to address emergency planning and preparedness. Has your agency participated in County or citywide emergency drills in the past year?

(2 Points – 2-Appropriate, 1-Adaquate, 0-Inadaquate) *Attachment 18 included?  Yes  No*

|  |
| --- |
| **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 19 included?  Yes  No*

**Private Non-profit Information**

|  |  |
| --- | --- |
| Legal Name of Non-profit Applicant: |  |
| State of California Articles of Incorporation Number: |  |
| Date of Incorporation: |  |
| *Attachment 20 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 21 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 22 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 Individuals with Disabilities (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. **Up to 90% of project cost or no greater than $1 million – funding request should consider staff and contingency costs, not to exceed a combined $1 million.** [↑](#footnote-ref-2)
2. **Minivan:** 5 Ambulatory Passengers (AP), includes ramp. **Small Bus:** 8 AP; 2 Wheelchair (WC) – Wheelchair refers to rear wheelchair lift floor plan.  
   **Medium Bus:** 12 AP; 2 WC. **Medium Bus – CNG:** Justify the need for a ZEV if requested.   
   **Large Bus:** 16 AP; 2 WC. **Large Bus – CNG:** Refer to Medium Bus – CNG. **Larger Bus:** 20 AP; 2 WC. [↑](#footnote-ref-3)
3. Estimated costs are to be filled out by the applicant, utilizing CalACT price guides is encouraged. Outside sources are also allowed. [↑](#footnote-ref-4)
4. Applicants should include tax, title fee, acquisition fees, etc. to provide the total cost of the vehicle over the lease term. [↑](#footnote-ref-5)
5. Total project cost will include Local Match + Vehicle Purchase(s) and/or Lease(s) + Equipment Request(s) + Staff Costs + Contingency Costs [↑](#footnote-ref-6)