|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 49 U.S.C. Section 5310 Program  ***Enhanced Mobility for Seniors and Individuals with Disabilities***  Subrecipient Application  Due to HDOT by COB: Thursday, June 30, 2022 | | | |
| **NOTE: Please complete all sections of this application. Application packages with incomplete and/or missing information will not be considered.** | | | | |
| **Agency Name:** | | | **DUNS No:** | |
| **Physical Address:** | | | | |
| **City:** | | **County:** | **Island:** | **Zip Code:** |
| **Contact Person:**  **(Project Manager)** | | | | |
| **Phone:** | | **Fax:** | **E-mail Address:** | |
| Check Area Project Application to Serve:   |  |  |  | | --- | --- | --- | | **Urbanized Area** | **Rural Area** | **Small Urbanized Area** | | **□ Oahu** | **□ Island of Hawaii** | **□ Kailua – Kaneohe** | |  | **□ Island of Molokai** | **□ Kahului** | |  | **□ Island of Lanai** |  | |  | **□ Island of Kauai**  **□ Island of Maui** |  | | | | | |
| **TOTAL GRANT AMOUNT REQUESTED**  **Federal Share (80% Grant Fund) …..…………..………….$\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_.\_\_\_\_\_\_\_**  **Local Share (20% Applicant Match) ………………...…….$\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_.\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Estimated Total Cost of Project(s)………………...……….$\_\_\_\_\_,\_\_\_\_\_\_\_\_\_\_\_.\_\_\_\_\_\_\_** | | | | |
| **Authorized representative certifying the information contained in this application is true and accurate:**  Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Applications must be transmitted to the attention of the following before the deadline:**  Honolulu Department of Transportation  Statewide Transportation Planning Office  ATTN: 5310 Program Manager  200 Rodgers Boulevard  Honolulu, Hawaii 96819  Fax: (808) 831-7995 or Email: [dotstp@hawaii.gov](mailto:dotstp@hawaii.gov)  **Please also include an electronic copy of your complete application package on a flash drive or via email to 5310 program manager.** | | | | |

**1. General Information – Applicant’s Information**

Name of Applicant Organization:

Address:

City: State: Zip Code:

Authorizing Representative and Title:

Name:

Title:

Telephone:

Fax:

Email:

Website:

Type of Business: (choose one)

Non-Profit Organization Government Entity



Transportation Provider (Private or Public)

Previous Section 5310 Funding: (check one)

Applicant Organization has received Section 5310 funds in the past. If yes, provide the last Fiscal year the Section 5310 Project was awarded.

[ ]



Applicant Organization has never received Section 5310 funding.

[ ]



Service Area: Choose one option that best describes the population size of the total service area.

Population less than 50,000 - Non-Urbanized Area



Population between 50,000 - 199,999 - Urbanized Area



Population equal to or greater than 200,000 - Urbanize Area

**2a. Applicant Organizational Structure**

Describe the overall structure of your organization. If available, provide an Organization Chart.

Number of Employees: (The number and type of your employees.)

Full-Time

Part-Time

Volunteer

Contract

Other (describe):

Other (describe):

Service Years: (Identify the number of years your organization has been in business and service years.)

year(s) Applicant Organization has been in business

year(s) transportation services were provided

year(s) transportation services were provided for the elderly and/or disabled

**2b. Applicant Organization's Transportation Management Information**

Describe the organization’s experience in providing transportation services for the elderly and/or disabled individuals.

Transportation Human Resources (Describe the employee position(s) your agency utilizes for transportation operations and management, roles and responsibilities, and number of hours performed by each per week.)

**3a. Transportation Information – Driver Selection and Training**

Check all items that you require of or consider in hiring your drivers.

|  |  |  |
| --- | --- | --- |
| [ | ] | Verify driver credentials and records |
| [ | ] | Physical examination |
| [ | ] | Drug and alcohol testing |
| [ | ] | Driver training |
| [ | ] | Driver experience |
| [ | ] | CDL |
| [ | ] | Other (describe): |

Check all training areas that your organization provides to your drivers.

|  |  |  |
| --- | --- | --- |
| [ | ] | Vehicle driving |
| [ | ] | Vehicle use |
| [ | ] | Vehicle equipment use, including ADA equipment |
| [ | ] | Ambulatory client vehicle assistance |
| [ | ] | Non-ambulatory client vehicle assistance |
| [ | ] | Service program that transportation is provided for |
| [ | ] | Vehicle pre- and post-trip check procedures |
| [ | ] | Vehicle maintenance and repair procedures |
| [ | ] | Vehicle accident procedures |
| [ | ] | Other (describe) |

**3b. Transportation Information – Vehicle Maintenance**

Check all items your organization requires for the maintenance of company vehicles.

|  |  |  |
| --- | --- | --- |
| [ | ] | Employee(s) are assigned to provide for vehicle maintenance |
| [ | ] | Vehicle regular maintenance policy |
| [ | ] | Vehicle preventive maintenance policy |
| [ | ] | Vehicle pre- and post-trip vehicle checklists |
| [ | ] | Vehicle unscheduled maintenance policy |
| [ | ] | Other (explain) |

Repair & Maintenance (Provide the name of repair and maintenance agencies that you use to service your vehicle fleet. If your repair and maintenance are done in-house, indicate so.)

1. Chassis Repair and Maintenance Service
2. Body Repair & Maintenance Service
3. Lift/Ramp/Gurney Equipment Repair & Maintenance Service

**3c. Transportation Services**

Coordinated Transportation Services (Describe your existing efforts in coordinating your transportation programs or services with other public, private service agencies and paratransit agencies. Describe benefits gained from this coordination effort, and any plans to expand your coordinated services.)

Transportation Service Changes (Describe any changes to your transportation services comparing past to current, reason for change, its impacts and future plans.)

**3d. Transportation Information – List All Non-FTA and FTA-Funded Vehicles In Your Fleet (repeat this page as necessary)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant Organization Name: | | | | | | | | | | |
| **Year** | **Make** | **Model** | **License Plate #** | **VIN** | **Odometer**  **Reading** | **Seating Capacity** | **W/C Lift or Ramp** | **# of W/C Tiedown** | **Program Name** | **5310**  **Yes/No** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

**4a. Applicant Organization’s Non-Transportation Programs - (describe one program**

**per page and repeat this page as necessary)**

Program Name:

1. Program Description – Type of Service Provided
2. Client Type & Characteristics

[ ] Elderly and/or Persons with Disabilities (describe) [ ] Other (describe)

1. Days & Hours of Program Operation

am

am

am

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Monday: : | am - : | pm | Friday: : | am - : | pm |
| Tuesday: : | am - : | pm | Saturday: : | am - : | pm |
| Wednesday: : | am - : | pm | Sunday: : | am - : | pm |
| Thursday: : | am - : | pm |  |  |  |

1. Average Number of Clients Served by the Program per Month

per month

1. Additional Information (attach a separate sheet if necessary)

is attached: YES NO

**4b. General Information – Applicant Organization’s Transportation Programs – (describe one program per page and repeat this page as necessary)**

Program Name:

1. Describe the Program’s Transportation Service:
2. Client Type & Characteristics:

[ ] Elderly and/or Persons with Disabilities [ ] Other - describe

1. Days & Hours of Program Operation:

Monday: Tuesday: Wednesday: Thursday:

**:** am - : pm

: am - : pm

am

am

**:** am - : pm

am

**:** am - : pm

Friday: Saturday: Sunday:

**:** am - : pm

**:** am - : pm

**:** am - : pm

1. Average Number of Clients Served by the Program per Month:

per month

1. Additional Information (attach a separate sheet if necessary):

is attached: YES NO

**5a. Project Information – Project Use (describe for each vehicle if applying for multiple vehicles and repeat page as necessary)**

Identify the program for which the vehicle will be used.

Program Name:

1a. Projected Monthly Primary Use

|  |  |  |
| --- | --- | --- |
|  | Projected Unduplicated Riders | Projected Single Trips |
| Elderly Non-Disabled |  |  |
| Non-Elderly Disabled |  |  |
| Elderly Disabled |  |  |
| Total |  |  |

1b. Describe the Primary Use of the vehicle you are applying for.

2a. Projected Monthly Incidental Use:

|  |  |  |
| --- | --- | --- |
|  | Projected Unduplicated Riders | Projected Single Trips |
| Non-Elderly Non-Disabled (clients of organization) |  |  |
| Staff/Volunteer/Other |  |  |
| Total |  |  |

2b. Describe the Incidental Use and how it will not affect the Primary Use of the transportation of the elderly and/or disabled.

1. Projected Monthly Percentages of Usage:

|  |  |  |
| --- | --- | --- |
|  | Projected Unduplicated Riders | Projected Single Trips |
| Primary Use | % | % |
| Incidental Use | % | % |

1. Transportation Service Area:
2. Transportation Service Benefits:
3. Passenger Fees or Fares per Single Trip:

**5b. Project Information – Project Need (describe for each vehicle if applying for multiple vehicles and repeat page as necessary)**

Describe the need and justification for the vehicle, how needs are determined and how the vehicle will address the needs.

**5c. Project Information – Project Benefits and Sustainability (describe for each vehicle if applying for multiple vehicles and repeat page as necessary)**

Describe the benefits to be gained by the program, applicant organization, public, community, government, elderly clients, disabled, non-elderly/disabled clients, economy etc.

Describe the deficiencies and shortcomings to the program’s existing and future services, or other negative outcomes that may arise should the project not be awarded.

**5d. Project Information – Vehicle Description (describe for each vehicle if applying for multiple vehicles and repeat page as necessary)**

Please select the vehicle type:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vehicle Type | Seating Capacity (including driver) | No. of Wheelchair Position(s) | Select Vehicle Type  (Check one only) | | |
| Minivan | 6 |  |  |  |  |
| Modified Raised Roof Van (Mid Roof) | 10 | 2 |  | | |
| Cutaway Van | 15 | 3 |  |  |  |
| Unmodified Raised Roof Van (Mid Roof) | 15 | N/A |  | | |

|  |  |
| --- | --- |
| A. Total Estimated Vehicle Cost | $  **.** |
| B. Federal Funds Requested – maximum amount is 80% of A | $ **.** |
| C. Applicant Organization Share – A minus B (must be at least 20% of Total Project Cost) | $ **.** |

Source of Share Cost: Identify the source of your organization’s share. Funds must be available before the project is awarded to the vendor.

Vehicle Use (check one only)

Replacement: The vehicle will be used to replace a similar vehicle in an existing transportation service program.

[ ]



* + Provide the license plate number of the proposed motor vehicle to be replaced:
  + If the proposed vehicle to be replaced is FTA-funded, has a Vehicle Disposal or Vehicle De-obligation Application been submitted to the department?  Yes  No

o If so, provide date.

Expansion: The vehicle will be used for an existing transportation service and will provide additional transportation service to this program.

[ ]



New Service: The vehicle will be used for a new transportation service for a new program or a program that does not currently have transportation service.

[ ]



**6. Financial Information**

Financial Statement - Provide and attach for the current or most recent period and two previous years. These statements will be used to review financial stability and sustainability.

Fluctuations in Revenue and Income - If fluctuations in estimated revenue or expenses vary or are expected to vary over the next two years, provide the reasons for the anticipated or actual fluctuations and how such fluctuations will affect the program's financial stability and sustainability.

**7. Legal Information**

Legal Resource (check one)

 The Applicant Organization has legal counsel

[ ]

 The Applicant Organization does not have legal counsel

[ ]

**8. Other Federal Requirements**

Non-Duplication of Transportation Services (check one) (Your organization is prohibited from providing any duplication of services to the elderly and/or disabled community unless there is an unmet need for such transportation service). The application must include at least:

Letters from public, private and para-transit operators within the Applicant Organization’s transportation service area notifying the Department indicating that their current and near future operations do not provide similar services proposed in the application.

[ ]



Efforts of notification to public, private and paratransit operators with similar transportation services within the Applicant Organization’s transportation service area. Please provide:

[ ]



* Copies of public notice in area newspapers with written comments from

other transportation providers indicating that your current and near future transit services are not similar; and/or

* The date and name of transportation providers contacted indicating that your current and near future transit services are not similar.

Private Non-Profit Organizations: Provide the following:

|  |  |  |
| --- | --- | --- |
| [ | ] | Copy of current Annual Domestic Non-Profit Corporation Exhibit or Non-Profit |
| [ | ] | Status Letter from the Internal Revenue Service; and  Copy of Incorporation Documentation |

Government Agencies: Certify that public entity does not provide same transportation services provided by private or para-transit operators.

[ ] Signed letter by the Director of the Government Agency and the Mayor of the County certifying that no other public, private or para-transit operator is willing and able to provide the transportation service of the Applicant Organization.

Title VI of the Civil Rights Act of 1964

[ ] Signed Title VI of the Civil Rights Act of 1964 assurance.

Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27

[ ] Signed Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27 assurance.

**9. Certifying Authority**

I am duly authorized to make the following certification on behalf of the Applicant Organization and based on my position, knowledge and experience with the Applicant Organization:

1. the information contained in the Application, including attachments, is true and correct;
2. the Applicant has the requisite fiscal, managerial, and legal capabilities to carry out the operations and maintenance of the Project in accordance with 40 U.S.C. Section 5310; and
3. the Applicant shall adhere to the federal, state and local requirements related to the Project.

,

Signature Title

Executed on at

Date City/County and State

State of Hawaii Department of Transportation

Statewide Transportation Planning Office

Standard Assurance with Regard to Nondiscrimination as Required by 49 CFR Part 27

Name of Applicant Organization:

Pursuant to the requirements of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) the aforementioned Applicant Organization in desiring to avail itself of Federal financial assistance from the United States Department of Transportation (USDOT), hereby gives assurance that no qualified handicapped person shall, solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination, including discrimination in employment, under any program or activity that receives or benefits from Federal financial assistance provided by the USDOT 49 U.S.C. Section 5310 Program.

The Applicant Organization further assures that its programs will be conducted, and its facilities operated, in compliance with all the requirements imposed by or pursuant to 49 CFR Part 27.

The person or persons whose signatures appear below are authorized to sign the assurance on behalf of the Applicant Organization.

Signed by: Date:

Print Name:

Title:

State of Hawaii Department of Transportation

Statewide Transportation Planning Office

Title VI of the Civil Rights Act of 1964 Assurance of Compliance

Name of Applicant Organization:

Hereby agrees that it will comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352) and all requirements imposed by the United States Department of Transportation (USDOT), to the end that, in accordance with Title VI of the Act, no person in the United States shall, on the ground of race, color or national origin, be excluded from participation, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant Organization receives Federal financial assistance from the Section 5310 Program; and herby gives assurance that it will immediately take any measures necessary to effectuated this agreement.

If any personal property is so provided this assurance shall obligate the Applicant Organization for the period during which it retains ownership or possession of the property. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant Organization by the USDOT under the Section 5310 Program, this assurance shall obligate that the Applicant Organization, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purposed involving the provisions of similar services or benefits. In all other cases, this assurance shall obligate the Applicant Organization for the period during which the Federal financial assistance is extended to it by the USDOT 49 U.S.C. Section 5310 Program.

This assurance is given in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant Organization by the USDOT under the 4 9 U . S . C . Section 5310 Program. The Applicant Organization recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant Organization; its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign assurance on behalf of the Applicant Organization.

Signed by: Date: Print Name:

Title: