

State of Hawaii
Department of Transportation
Statewide Transportation Planning Office

CAPITAL ASSISTANCE FOR THE TRANSPORTATION
OF THE ELDERLY AND DISABLED

APPLICATION



2007

Deadline to submit application is October 15, 2008

In accordance to 49 USC Section 5310

IA. General Information

This FTA 5310 application package consists of two documents: The Application document, and the Information document. The latter provides more detailed information about the application process to assist you. Both documents may be downloaded from the Hawaii Department of Transportation website.

In completing this Application refer to the "Application Instructions section" of the Capital Assistance for the Transportation of the Elderly and Disabled "Information" document.

Name of Applicant Organization

Address

Organization Director and Title

Telephone []

Fax []

Email []

Website []

Type of Business (check one)

Private Non-profit Organization

Public Entity

Previous Section 5310 Recipient Organization (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. []

Application Organization has never received Section 5310 funding.

Service Area (Identify the service area e.g. name of region, community, town & check one the block that best describes the total service area's population size)

Population less than 200,000 – Non-Urbanized Area

Population equal or greater than 200,000 – Urbanized Area

IB. General Information

Services of Organization (Identify the group and type of services provided. E.g. Elderly, and Disabled. Social, health, work, training, rehabilitation etc.)

Program Name []

1. Social, Health and/or Transportation Services Provided

2. Client Type & Characteristics

3. Days & Hours of Program Operation

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

5. Additional Information (attach separate sheet if necessary)

IC. General Information

Services of Organization – Other Programs (Identify programs your organization provides that do not serve Elderly and Disabled individuals. May include low income or welfare.)

Program Name []

1. Social, Health and/or Transportation Services Provided

2. Client Type & Characteristics

3. Days & Hours of Program Operation

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

5. Additional Information

IIA. Transportation Information

Ethnic Groups and Gender Serviced By Your Organization's Transportation Services:
Indicate the number of individuals served per month (indicate number of persons.)

- | | | | | | |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | White | <input type="checkbox"/> | <input type="checkbox"/> | Vietnamese |
| <input type="checkbox"/> | <input type="checkbox"/> | Hawaiian/Part Hawaiian | <input type="checkbox"/> | <input type="checkbox"/> | Samoan |
| <input type="checkbox"/> | <input type="checkbox"/> | Chinese | <input type="checkbox"/> | <input type="checkbox"/> | Hispanic |
| <input type="checkbox"/> | <input type="checkbox"/> | Japanese | <input type="checkbox"/> | <input type="checkbox"/> | African American |
| <input type="checkbox"/> | <input type="checkbox"/> | Filipino | <input type="checkbox"/> | <input type="checkbox"/> | American Indian/Alaskan |
| <input type="checkbox"/> | <input type="checkbox"/> | Korean | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Gender

- | | | | | | |
|--------------------------|--------------------------|------|--------------------------|--------------------------|--------|
| <input type="checkbox"/> | <input type="checkbox"/> | Male | <input type="checkbox"/> | <input type="checkbox"/> | Female |
|--------------------------|--------------------------|------|--------------------------|--------------------------|--------|

Driver Selection (check items that you require of or consider in hiring your drivers.)

- | | | | |
|--------------------------|--------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Verify driver credentials and records | |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical examination | |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug and alcohol testing | |
| <input type="checkbox"/> | <input type="checkbox"/> | Driver training | |
| <input type="checkbox"/> | <input type="checkbox"/> | Driver experience | |
| <input type="checkbox"/> | <input type="checkbox"/> | CDL | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Driver Training (check training areas that your organization provides to your drivers.)

- | | | | |
|--------------------------|--------------------------|---|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle driving | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle use | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle equipment use, including ADA equipment | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory client vehicle assistance | |
| <input type="checkbox"/> | <input type="checkbox"/> | Non-ambulatory client vehicle assistance | |
| <input type="checkbox"/> | <input type="checkbox"/> | Service program that transportation is provided for | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle pre- and post-trip check procedures | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle maintenance and repair procedures | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vehicle accident procedures | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

IID. Transportation Information

Client Transportation Services (Identify and provide information on the transportation services that your agency provides to your clients. If no transportation services are provided, indicate so.)

Program Name []

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	
Fixed Route	
Total Percentage	

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

5. Additional Information

IIIA. Project Information

Project Description (Describe the project e.g. replacement of vehicles, expansion, or new service, and submit project specifications and plans.)

Type of Project Use (check one)

Replacement. Also, provide the license plate number of the proposed motor vehicle to be replaced.

[]

Expansion

New Service

IIIB. Project Information

Project Use Information (Provide the “use” of the project and identify the program for which the project will be used for.)

Program Name []

1. Single Trips per Month with Proposed Project

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

2. Transportation Service Area

3. Transportation Service Benefits

4. Driver Characteristics

5. Client Assistance Provided

6. Passenger Fees or Fares per Single Trip

IIIC. Project Information

Project Primary & Incidental Use (check one)

- Primary Use only
- Primary and Incidental Use. Describe the Incidental Use and how it will not affect the Primary Use of the transportation of the elderly and/or disabled as described in the Application.

Project Cost Estimate

A. Total Project Cost Estimate	
B. Federal Funds Requested – maximum amount is 80% of A	
C. Applicant Organization Cost – A minus B (must be at least 20% of Total Project Cost)	

Project Procurement (check one)

- The Department to procure project
- Agency other than the Department to procure project

Need for Project (Describe the need and justification for the project, how needs are determined and how project will address these needs.

IIID. Project Information

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

Deficiencies if Project is Not Awarded (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.)

Project Equivalent Service (check one and if the 2nd is checked, provide information)

- The project proposed in the Application is accessible.
- The project proposed In the Application is non-accessible and Equivalent Service is provided. Provide the Equivalent Service policy and/or describe the Equivalent Service practice of the Applicant Organization.

Equipment Service Life (For project equipment that have a Service Lilfe less than 4-years, describe and provide documentation for the basis of the equipment service life).

IV. Financial Information

Provide and attach with this application your organization's Financial Statement 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 reasons for the anticipated or actual fluctuations and how such fluctuations will affect the program's financial stability and sustainability.)

Source of Share Cost (Identify the source of your organization's project cost. Funds must be available before the project is awarded to the vendor which is 12 – 18 months after Application approval.)

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

VI. Legal Information

Legal Resource (check one)

- The Applicant Organization has legal counsel
- The Applicant Organization does not have legal counsel

VIIA. 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 Hawaii State Department of Transportation 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. 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
 - Provide the date and name of transportation providers contacted indicating that your current and near future transit services are not similar.

VII.B. Other Federal Requirements

Private Non-Profit Organizations (Non-profit agencies only, check all.) 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

Public Entities (government agencies only. 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 (check one)

- Completed and signed Title VI of the Civil Rights Act of 1964 assurance.

Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27 (check one)

- Completed and signed Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27 assurance.

VIII. 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.

Executed on _____ at _____
Date City/County and State

_____, _____
Signature Title