Delaware Transit Corporation FY 2022 Application for FTA Section 5310 Program

Due: FEBRUARY 4, 2022

NOTE: Please complete all sections of this application, Application packages with incomplete information and/or Missing information will not be considered for funding

PURPOSE OF APPLICATION VEHICLE REQUEST_____ TO PROVIDE TRIPS_____

Agency (Applicant) Name:	Duns Number
Physical Address (No P.O. Box)	

City County Zip

Contact Person

Phone	FAX	E-Mail Address

Name of Authorizing Representative certifying to the information contained in this application is true and accurate:

Printed Name:_____ Title:_____

Signature (Authorizing Representative)_____

Email: _____ Phone Number: _____

Delaware Transit Corporation
DART First State
119 Lower Beech St.
Wilmington, DE 19805

If Agency is interested in providing trips to their facility, please submit a letter of intent.
If Agency is applying for vehicles, please complete the full application

Coordinated Plan Certification

In 2012, Congress enacted MAP-21 continued the requirement that projects funded with 5310 funds be derived from a locally developed, coordinated public transit-human services transportation plan. In order for an application to be considered for funding it must be derived from one of the locally developed, coordinated public transit-human services transportation plans for the State of Delaware.

You must list how your request for a vehicle meets an **unmet need or a coordination strategy identified** in the New Castle County, Kent County or Sussex County Coordinated Transit/Transportation Plans.
(These Plans are available on DART'S Website - DARTFIRSTSTATE.com) click on DART programs,
Then on 5310 programs, the coordination plans can be found under programs.

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SECTION I - SERVICE DESCRIPTION

1. Type of Application (Check only one)

(a) Replacement of existing 5310 vehicle (a)_____

(b) Expansion of current 5310 fleet (b)_____

(c) New to the 5310 Program (c)_____

If you are requesting replacement equipment, explain why the vehicle(s) need replacement in order to ensure continuance of existing services.

_____

_____

_____

_____

Vehicles to be replaced:

Year	VIN Number	Mileage	12 Month Maintenance & Repair Costs

If you are requesting an expansion bus please explain the 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. Use a separate sheet of paper if necessary.

_____

_____

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_____

2. Total size of fleet after acquisition (check only one):

+10	(a)_____
5 - 9	(b)_____
4 or less	(c)_____

3. How would you use this equipment if granted (check all that apply):

Expand to new clients	(a)_____
Expand to non-agency clients	(b)_____
Expand to new area	(c)_____
Extend hours of service	(d)_____
Increase frequency of service	(e)_____
Subcontract services	(f)_____
Maintain existing services	(g)_____

4. (A) Anticipated number of **elderly and/or disabled persons** eligible for 5310 transportation service:

_____ number of persons

(B) Anticipated total annual **elderly and/or disabled** passenger trips* per requested vehicle:

_____ number of annual passenger trips

* Passengers are counted each time they board the vehicle and travel from their origin to their destination.

5. Current vehicle fleet (attach additional sheet if necessary) (list vehicles acquired through DTC only)

Year	VIN #	Mileage

SECTION II- TYPE OF EQUIPMENT (Number your first & second choice) Please note that there is no guarantee that your choices will be awarded.

1. Ford E450, 16 passenger paratransit bus _____
2. Ford Transit 11 passenger with flip seats For up to 3 wheelchairs and 5 seated passengers _____
3. Dodge Caravan with a wheelchair ramp for 1 wheelchair and 3 seated passengers _____

SECTION III - CLIENTELE SERVED

1. What type of program(s) will requested equipment be used for (check all that apply)

Client Type
Elderly _____
Disabled _____

Transportation Purpose
Medical _____
Education _____
Nutrition _____
Shopping/Personal _____
Recreational/Social _____
Employment/Training _____
Other _____

if Other, please list: _____

_____

2. Programs listed above are (check only one):

Are currently provided by agency (a)_____
Would be new service for existing clientele (b)_____
Would be new/existing service to increase clientele (c)_____

3. Will service with requested equipment be available to non-agency clients?

Yes (a)_____
No (b)_____

4. (A) Days of the week that the vehicle would be operating (circle all applicable days):

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

(B) Operating hours for vehicle requested: _____ total hrs per day: list hours _____

(C) Geographic operating area currently served (Check all that apply):

New Castle County _____
Kent County _____
Sussex County _____

5. How will the vehicle requested assist the overall transportation needs of the community: Please describe in detail what your agency does, what services for the elderly and/or disabled you provide and how the vehicle will be used within your agency. Submit on a separate sheet if necessary.

If you are new to the 5310 program you must submit with your application any brochure, pamphlet, agency program listing, etc., that validates the description listed below. If your are new to the 5310 Program but your agency currently has a transportation program please include current operating statistics such as, hours, miles, services days and daily ridership.

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SECTION IV - TRANSPORTATION ALTERNATIVES

1. Client dependency on agency transportation (**check only one**):
   - entirely dependent on agency, there are no other means of transportation currently available (a)_____
   - partially dependent, other means of transportation are available (b)_____

2. DTC fixed-route service is available in service area: Yes (a)_____
   No (b)_____

3. DTC or other paratransit transportation services are available to meet travel requirements: Yes (a)_____ No (b)_____

If no, explain why:_____

_____

_____

4. Will the acquisition of the equipment requested in this application decrease the agency's usage of DTC paratransit service?

Yes _____ No _____

5. Will the acquisition of the equipment requested in this application decrease the agency's usage of DTC fixed route service?

Yes _____ No _____

SECTION V - APPROPRIATENESS OF SERVICE

1. If applicant is unsuccessful in obtaining equipment, the probable consequences are (**check only one**):

(A) programs designed to serve individuals whose needs are now unmet due to a lack of transportation would not be started (a)_____

Explain: _____

_____

(B) existing programs can be maintained but no improvement will be made to the mobility of elderly and disabled persons (b)_____

Explain: _____

_____

(C) existing programs must be curtailed or eliminated (c)_____

Explain: _____

_____

2. Why does your agency want to provide transportation services:

_____

_____

_____

_____

_____

SECTION VI - COORDINATION EFFORTS

1. Check which of the following your agency has contacted during the past year in an effort to coordinate services?

_____ Area Agency on Aging	_____ County Government
_____ City Government	_____ Medical Agency
_____ Group Home	_____ Nursing Home
_____ Hospital	_____ Taxi Operator
_____ Private Operator	_____ Senior Center

Total Number Checked (a)_____

2. Briefly describe your coordination efforts and the results:_____
_____

_____

3. Are there organizational impediments to coordination within your agency:
(Example: Restrictions described in Charter)

Yes (a)_____
No (b)_____

If yes, please explain: _____

4. Is your agency willing to make organizational changes that will allow it to participate in a coordination effort:

Yes (a)_____
No (b)_____

5. Would your agency be interested in an Interagency Agreement to provide service to other agencies lacking transportation services:

Yes (a)_____
No (b)_____

SECTION VII - OPERATING INFORMATION

1. Driver Training (**check only one**):

a. drivers will be given several hours of training and on-the-job instruction. Those assigned to handicapped accessible vehicles will be given additional training. (a)_____

b. drivers will be given on-the-job training by a supervisor who will accompany the driver on the first several trips. (b)_____

c. no special training will be given (c)_____

2. Has your organization provided any of the following special training to your employees during the last year? (Check all that apply)

Emergency Procedures	(a)_____
Accident Reporting	(b)_____
Sensitivity Training	(c)_____
Defensive Driving	(d)_____
Wheelchair Lift Operations	(e)_____
Passenger Assistance	(f)_____
Other:_____	(g)_____

3. Vehicle Storage (**check only one**):

- vehicle will be stored in a fenced location at agency (a)_____
- vehicle will be stored at home of driver (b)_____
- no storage provisions made as of yet (c)_____

If not stored at the agency's location, explain where the vehicle will be stored:

_____

_____

4. When selecting drivers, do you (check all that apply)

- check driving record (a)_____
- require a commercial drivers license with passenger endorsement (b)_____
- require physical examination (c)_____
- require illegal substance screening (d)_____

SECTION VIII - FISCAL, CAPITAL and TECHNICAL CAPABILITIES

1. How many years has your organization provided transportation services in your area?

_____ # of years

2. Dependency on Section 5310 funding (**check only one**)

If funding is not available for equipment purchase, agency could potentially access other funding sources (a)_____

If funding is not available, equipment will not be acquired (b)_____

Has your organization applied for equipment funding from other sources. If so, please list sources and amounts requested:

Yes _____

No _____

Funding Source	Amount Requested
_____	_____
_____	_____

_____ _____

3. Contributed Capital (if your agency pledges any money and is selected for an award, DTC will require that your agency submit the money when the vehicle order is placed)

$_____

How will payment of Contributed Capital be made: (ie. Check from agency or contribution from local elected official) _____

4. Please indicate the status of your agency(check only one):

_____Private nonprofit organization
_____Public agency (state or local governmental authority)
_____Provider of public transportation services (includes private operators of public transportation services).

5. Who will be responsible for the administration of the 5310 program within your agency? List their name and phone number along with a summary of their job responsibilities.

_____
_____
_____
_____

6. You must include with this application an organizational chart for your agency that identifies the positions that are responsible for the administration of this program.

NOTE: The following certification must be completed by the person in your agency who is responsible for fiscal management. Failure to complete this portion **will** result in your application not receiving consideration for funding.

I certify that, based on my experience with

_____,
(Agency Name)

and a review of the organizational records, that the organization has the requisite fiscal and managerial capabilities to carry out the proposed project.

_____ _____
Signature of Official of the Organization Date

_____

Print name of Official of the Organization

SERVICE BREAKDOWN, BY RACIAL CLASSIFICATION AND NATIONAL ORIGIN

AGENCY NAME: _____

1. Projected number of individuals to be serviced monthly by Section 5310 vehicle(s):

_____ # of individuals

Number of Black individuals included in #1	_____%
Number of Hispanic individuals included in #1	_____%
Number of Asian individuals included in #1	_____%
Number of White individuals included in #1	_____%
Other, please specify _____	_____%
TOTAL (must be 100%)	_____%