**AGENCY NAME/DBA (both)**

**DUNS# Congressional District**

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| **LEAD AGENCY:** | **PAGE #** | **CABINET USE ONLY** |
| 1. **Type of Project**
 |  |  |
| * Traditional Capital Project – Replacement Vehicles
 |  |  |
| * Project(s) Exceed Requirements of ADA, Improve Access to Fixed Route Services and/or Alternatives that Assist Seniors and Individuals with Disabilities (Formerly 5317 New Freedom)
 |  |  |
|  |  |  |
| 1. **Summary Page**
 |  |  |
| * All Agencies Contacted/Dates Listed
 |  |  |
| * Needs Ranked
 |  |  |
| * Coordination Meeting(s) Listed (if applicable)
 |  |  |
| * Milestone Schedule
 |  |  |

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| 1. **Notification**
 |  |  |
| * Copy(s) of Letter and/or List of Agencies
 |  |  |
| * Private Sector Notified
 |  |  |
| * Groups Serving Minorities Notified
 |  |  |
| * Copies of Certified Receipts
 |  |  |
| * Coordination Meeting(s) Summarized (if applicable)
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| 1. **Requirements**
 |  |  |
| * Fiscal/Managerial Capability of Lead Agency & Applicants
 |  |  |
| * Title VI: Minorities Served Estimated by Category
 |  |  |
| * Equivalent Service Analysis of Lead Agency & Applicants
 |  |  |
| * Preventive Maintenance Program and Forms
 |  |  |
| * Articles of Incorporation for Lead Agency & Applicants
 |  |  |
| * Legal Name Form for Lead Agency & Applicants
 |  |  |
| * Operating Funds and Local Match:
 |  |  |
| * Letter(s) from Agency(s) Providing Operating Funds for Vehicle
 |  |  |
| * Letter(s) from Agency(s) Providing Required Local Match
 |  |  |
| * Description of Incidental Services & Cost Recovery such as: Meal Delivery
 |  |  |
| * Status of Open 5310
 |  |  |
| 1. **Assurances**
 |  |  |
| * Certifications and Assurances
 |  |  |
| * Authorizing Resolution
 |  |  |
| * Signed Federally Required Model Contract Clauses
 |  |  |

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| 1. **Assessments for Each Agency**
 |  |  |
| * Each County’s Needs Addressed
 |  |  |
| * One Complete Form per Vehicle (Preliminary Assessment)
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| 1. **Specifications**
 |  |  |
| * Capital Equipment Request Specifications, Bid Package and/or Quotes with Independent Cost Estimate for each Capital type of request
 |  |  |
| 1. **Coordinated Plan**
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| * Coordinated Plan Attached
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| * Coordinated Plan Checklist Attached (Fully Completed and Signed)
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Agency Signature Title Date

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State/OTD Project Manager Signature Title Date

\_\_\_\_\_\_\_\_ State/OTD Staff Assistant or Branch Manager Acknowledgement

Initials

**\*\***All elements must be checked or marked N/A, by the Project Manager, for an application to receive State and Federal Approval.