**AGENCY NAME/DBA (both)**

**DUNS# Congressional District**

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| **PART I PLANNING & PROGRAMMING** | **PAGE #** | **CABINET USE ONLY** |
| 1. **Project Description** |  |  |
| * Updated Project Description (Routes, Fares, Hours, Days, etc.)   (Please include Rural Public, Appalachian, Intercity Bus, etc.) |  |  |
| * Appalachian Counties listed (if applicable) |  |  |
| * HSTD/NEMT Involvement/Participation |  |  |
| * Vehicle/Facility Maintenance Plans |  |  |
| * Fixed Route/Supplemental ADA Paratransit |  |  |
| * Deviated or Flexible Fixed Route |  |  |
| * Demand-Response |  |  |
| * Intercity Bus Assurance and Description |  |  |
| * Incidental Services/Cost Recovery (Facilities, Charter, Meals, etc.) |  |  |
| * Updated Equipment/Rolling Stock/Real Property Inventory Listing |  |  |
| * Maps of Service Area for each service (Demand Response/Intercity, etc.) |  |  |
| * Articles of Incorporation/Transit Authority/Local Gov (current) |  |  |
| * Legal Name Form |  |  |
| * Updated Drug & Alcohol Policy |  |  |
| * List of Safety Sensitive Employees (w/o SS#) including Job Titles |  |  |
| * Low Income Population for Service Area |  |  |
| * Disabled Population for Service Area |  |  |
| * Training Conducted during Current and One (1) Past Fiscal Year |  |  |
| * Status of Open 5311/5309/5339 Capital Projects with Updated Milestones |  |  |
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| 1. **Project Justification** |  |  |
| * Benefits/Changes/Impact |  |  |
| * Personnel |  |  |
| * Relationship to Community |  |  |
| * Local Support Letters |  |  |
| * Inaccessible Vehicle Purchase |  |  |

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| 1. **Project Budget(s)** |  |  |
| * Separate Budget for each Applicable Service (Operating, Administrative, Appalachian, Intercity, Intercity Administrative) |  |  |
| * Separate **Detailed** Backup for **each** Line Item on **each** Budget |  |  |
| * Explain Non-Emergency Medicaid Involvement in Detail |  |  |
| * Indirect Line Item (Approved Non-Profit Rate Agreement) |  |  |
| * DBE/WBE Goal |  |  |
| * In-Kind Backup Documentation/Justification |  |  |
| * RTAP Needs Explained & Budget(s) |  |  |
| * RTAP Application Spreadsheet |  |  |
| * Source(s) of Contract Revenue w/Description of Services Provided |  |  |

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| 1. **Purchase Requirement(s)** |  |  |
| * Annual Equipment Certification |  |  |
| * Agency Purchase Procedures (one-time only) |  |  |
| * Bid or Quote Specifications with Bid Package and ICE for **each Item Requested** |  |  |

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| 1. **Planning** |  |  |
| * Monitoring Agency(s) (Board, Commission, State, ADD, etc.) |  |  |
| * Studies & Dates |  |  |
| * Two One-Year Operating Budgets (SFY21 & SFY22) |  |  |
| * Three One-Year Capital Budgets (SFY20, SFY21 & SFY22) |  |  |
| * Population of Service Area by County |  |  |
| * Community Development Projects Description |  |  |

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| **PART II COMPLIANCE** |
| 1. **Coordination Meeting** |  |  |
| * Certified Mail/Returned Receipts |  |  |
| * Providers Notified/Copy of Letter |  |  |
| * Participants/Summary |  |  |

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| 1. **Public Hearing (if necessary)** |  |  |
| * Copy of Advertisement/Proof of Publication |  |  |
| * Participants/Certified Verbatim Transcript |  |  |
| * LEP Accommodations |  |  |

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| 1. **Private Sector Participation** |  |  |
| * Dates/Early Notification/Consultation |  |  |
| * Description of Proposals Received |  |  |
| * Rationale for Inclusion/Exclusion |  |  |
| * Methods for Periodic Service Review |  |  |
| * True Cost Comparison Methodology |  |  |
| * Complaints/Resolutions |  |  |
| * Written Local Complaint Process |  |  |

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| 1. **Certifications and Assurances** |  |  |
| * FY2020 Certifications and Assurances |  |  |
| * Signed Federal Model Clauses |  |  |
| * Equivalent Service Analysis |  |  |
| * Authorizing Resolution |  |  |
| * Local Share Resolution |  |  |
| * DBE/WBE Policy Statement |  |  |
| * Legal Name of Entity/Applicant |  |  |
| * Standard DOT Title VI Assurances |  |  |

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| 1. **Title VI** |  |  |
| * LEP Access Plan |  |  |
| * Affirmative Action Plan (100 or more employees) |  |  |
| * One Time Title VI Documentation |  |  |

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| 1. **Elderly and Persons with Disabilities** |  |  |
| * Hearing (if service for disabled changed) |  |  |
| * Status Report on Service for Disabled **DUE in FY20 Application** |  |  |

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| 1. **Opinion of Counsel** |  |  |
| * Current Letter from Counsel |  |  |

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| 1. **Labor** |  |  |
| * Letter to KYTC |  |  |

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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.