

**PRELIMINARY ASSESSMENT/APPLICATION FOR CAPITAL ASSISTANCE  
FOR AGENCIES SERVING THE MOBILITY NEEDS OF SENIORS AND INDIVIDUALS WITH  
DISABILITIES - SECTION 5310 GRANT SFY 2022**

1. Identification of Applicant Agency or Organization:

- a. Lead Agency Name: \_\_\_\_\_
- b. Applicant Agency: \_\_\_\_\_
- c. Address: \_\_\_\_\_
- d. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- d. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_
- e. Project Director or Supervisor: \_\_\_\_\_
- f. E-mail/Internet address: \_\_\_\_\_

2. Name of geographic area(s) to be served:

- a. Cities and/or Counties served: \_\_\_\_\_  
\_\_\_\_\_

3. Types of transportation service to be provided: (% of use)

<b>Scheduled, Fixed Route</b>	<b>Scheduled, Non- Fixed Route</b>	<b>Demand Response</b>	<b>Complementary Paratransit</b>	<b>Other: Specify: _____</b>

4. Vehicle or other equipment requested:

Vehicle Type: \_\_\_\_\_

Total Cost: \$ \_\_\_\_\_ Local Match: \$ \_\_\_\_\_

Equipment Type: \_\_\_\_\_

Total Cost: \$ \_\_\_\_\_ Local Match: \$ \_\_\_\_\_

Local Match Source(s): \_\_\_\_\_  
\_\_\_\_\_

Equipment Description and benefits for the services/riders: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Vehicle is intended to:

Mark with X

- Replace Existing Service	
- Expand Existing Service	
- Start New Service	
- Beyond ADA Specs (5310)	
- Other	

6. If new vehicle is intended to replace existing service, indicate the following for the vehicle to be replaced/rehabilitated:

Complete VIN#: \_\_\_\_\_ Years Owned: \_\_\_\_\_  
 Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_  
 Current Mileage: \_\_\_\_\_ as of (Date): \_\_\_\_\_ Condition: \_\_\_\_\_  
 Capacity: \_\_\_\_\_ Lift Equipped: \_\_\_\_\_ Ramp: \_\_\_\_\_

7. Estimate the number of one-way trips per month by county (for vehicle being replaced, not total fleet): (5310 Only)

	County	County	County	Total
Seniors				
Disabled				
Minorities				
Other				
Total				

8. Identify the clientele category your agency will serve (Please mark with X):

Seniors	Disabled: Physically	Disabled: Mentally	Minorities: Black	Minorities: Hispanic	Minorities: Asian	Minorities: American/Indian/Alaskan	Minorities: Low Income

Other specific client groups (specify): \_\_\_\_\_

9. Project Description: (Use more sheets if necessary)

a. How will the proposed vehicle fit into these services: \_\_\_\_\_  
 \_\_\_\_\_

b. Will the proposed vehicle be used for other services such as “Meals on Wheels”? If yes, please describe:

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c. Describe how the vehicle or equipment exceeds the ADA, improves access to fixed route services or is an alternative to public transportation to assist senior and individuals with disabilities:

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d. Describe agency fleet, giving number of Section 5310, 5311, 5309, 5339, 5339(b) and agency vehicles, as well as average age, mileage and accessibility of each:

<u>Grant</u>	<u>Total # of Vehicles</u>	<u>Average Age</u>	<u>Mileage</u>	<u>Accessibility</u>
5309				
5310				
5311				
5339				
5339(b)				
Agency				
<b>Total:</b>				

f. Discuss how you plan to coordinate services with other agencies serving the seniors and persons with disabilities and with other programs such as Section 5311, Job Access, etc. Discuss efforts to coordinate with other providers, especially taxi companies:

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g. Local Match Source(s):

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Transit Agency Signature

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Date

\*Please complete a separate application for each vehicle requested. A request from an applicant for a single vehicle serving more than one (1) county can be applied for on a single form. EVERY section of the form should be addressed or the requested vehicle’s overall ranking could be compromised.