Michigan Department
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# FY 2020 ADA COMPLAINT INFORMATION

*You must retain copies of complaints for at least one year and a summary of all complaints for at least five years.*

**Name Of Applicant (legal organization name)**

MDOT Agency

**Has the agency been named in any lawsuits or complaints in the last year which allege an individual was discriminated against or denied full participation in transportation based on disability?**

○ Yes ◉ No

**In the last year, have you had an ADA compliance review conducted on your transportation program as part of an overall FTA or MDOT Compliance Review?**

○ Yes ◉ No

**Have any changes been made to your ADA Complaint Policy?**

○ Yes ◉ No

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# FY 2020 SECTION 5310

## BUDGET DATA

**Budget Data Form is only required for agencies that do not submit an operating OAR in PTMS.**

**Name Of Applicant (legal organization name)**

MDOT Agency

| REVENUE SCHEDULE | | FY 2020 |
|---|---|---|
| Passenger Fares(paid by rider) | | $ |
| Contract Fares (paid by another organization) | | $ 1,949,481 |
| Local (source) | HEALTHWEST MU/CMH | $ 312,539 |
| | | $ |
| State (source) | JARC | $ 46,585 |
| | SPECIALIZED SERVICES BOTH | $ 139,058 |
| Federal (source) | JARC MDOT Agency | $ 46,585 |
| | NEW FREEDOM | $ 69,850 |
| Other (source) | FUEL TAX REBATE | $ 27,745 |
| | MOBILITY MANAGEMENT MDOT Agency | $ 5,000 |
| Total Operating Revenue | | $ 2,596,843 |

| EXPENSE SCHEDULE | |
|---|---|
| Labor and Fringe Benefits | $ 1,613,283 |
| Services, Materials and Supplies (gas, oil, work performed by another agency) | $ 460,325 |
| Casualty and Liability insurance | $ 77,171 |
| Purchased Transportation Service Within Service Area | $ |
| Leases and Rentals | $ 10,556 |
| Depreciation and Amortization | $ |
| All Other | $ 435,508 |
| Total Operating Expenses | $ 2,596,843 |

Michigan Department Of Transportation 3076

# FY 2020 CONTRACT CLAUSES CERTIFICATION



**I acknowledge that I have reviewed a copy of the Contract Clauses. I understand that the nature of the project will determine which requirements of the contract clauses apply and I will comply with all applicable clauses for all FTA-funded contracts for the application year.**

**Name Of The Person Authorized To Sign A Contract Or Project Authorization**

Enter Name

**Legal Organization Name**

MDOT Agency

| Title Of Authorized Signer | Signature Of Authorized Signer ** *(See Below)* | Date |
|---|---|---|
| EXECUTIVE DIRECTOR | | 02/15/2019 |

**** If the organization has a master agreement with MDOT, the organization name must match the name as it appears on the master agreement and the signature must be the same as the authorized signer of the master agreement or an individual with legal authority to sign a project authorization for the organization. Your agency can change, add or remove and authorized signer at any time by completing a signature resolution.**

**Michigan Department Of Transportation 3079**

# FY 2020 FTA CERTIFICATIONS AND ASSURANCES

**Name Of Applicant (legal organization name)**

MDOT Agency

The Applicant agrees to comply with the applicable requirements of Groups 1-15. ☑
Those requirements that do not apply to you or your project will not be enforced.

| Categories | Descriptions |
|---|---|
| 01. | Required Certifications and Assurance for Each Applicant. |
| 02. | Lobbying. |
| 03. | Procurement and Procurement Systems. |
| 04. | Pivate Sector Protection. |
| 05. | Rolling Stock Reviews and Bus Testing. |
| 06. | Demand Responsive Service. |
| 07. | Intelligent Transportation Systems. |
| 08. | Interest and Financing Costs and Acquisition of Capital Assets by Lease. |
| 09. | Transit Asset Management Plan and Public Transportation Agency Safety Plan. |
| 10. | Alcohol and Controlled Substances Testing. |
| 11. | Grants for Buses and Bus Facilities and Low or No Emission Vehicles Deployment Grant Programs. |
| 12. | Seniors and Individuals with Disabilities Programs. |
| 13. | Formula Grants for Rural Areas Program. |
| 14. | Tribal Transit Programs (Public Transportation on Indian Reservations Programs). |
| 15. | Hiring Preferences |

FTA and MDOT intend that the certifications and assurances the Applicant has selected on this form should apply, as required, to each project for which the Applicant seeks FTA assistance during application year.

The Applicant affirms the truthfulness and accuracy of the certifications and assurances it has made in the statements submitted herein with this document, and acknowledges that the provisions of the program Fraud Civil Remedies Act of 1986, as amended, 31 U.S.C. 3801 et.seq., and implemented by DOT regulations, “Program Fraud Civil Remedies,” 49 CFR part 31 apply to any certification, assurance, or submission made to FTA. The criminal fraud provisions of 18 U.S. C. 1001 may apply to any certification, assurance, or submission made in connect with any program administered by FTA.

Michigan Department
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# FY 2020 SECTION 5310/NEW FREEDOM
# GENERAL INFORMATION

**Name Of Applicant (legal organization name)**

MDOT Agency

**Check One :**

(●) **Urbanized Area** ( ) **Non Urbanized Area**

**Name of urbanized area**

e.g.,MUSKEGON

**Is your agency within a metropolitan planning organization (MPO)?**

(●) **Yes** ( ) **No**

**Has the project been included in the transportation improvement program (TIP) for this area?**

(●) **Yes** ( ) **No**

**Services Provided by applicant (including how 5310 vehicles will be used, service area, days and hours of operation, and reservation requirements)**

PIONEER RESOURCES PROVIDES TRANSPORTATION SERVICES FOR INDIVIDUALS WITH DISABILITIES AND SENIORS TO WORK AND COMMUNITY BASED SUPPORT SERVICES. THESE DESTINATIONS INCLUDE: MEDICAL APPOINTMENTS, CONGREGATE MEAL SITES AND WORK SITES THROUGHOUT THE COUNTY OF MUSKEGON. HOURS OF OPERATION ARE 6AM TO 6PM, MONDAY THROUGH FRIDAY.

**Estimated Percentage of Ridership(%)**

**Elderly** 49 % **Disabled** 51 % **Other** 0 %

**Specify Other**

**Vehicles are intended to:**

[x] **Replace Existing Vehicles** [ ] **Expand Existing Service** [ ] **Start New Service**

**Select One:**

( ) **Attached are letters of support from each public and private transit and paratransit operator in the proposed service area indicating that he or she does not, andis not intending to, offer similar service in the same area; or proof of a good faith effort made in obtaining letters of support if an operator will not respond.**

(●) **A public notice has been published (attach a copy of published public notice in PTMS).**

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# FY 2020 SECTION 5310 COORDINATED PUBLIC TRANSIT - HUMAN SERVICES TRANSPORTATION PLAN INFORMATION

**Project 1**

**Name Of Applicant (legal organization name)**

MDOT Agency

| **Project Type** | **Project Description** |
|---|---|
| Revenue vehicle | CAPITAL REQUEST FOR REPLACEMENT VEHICLES |

| **TITLE OF COORDINATED PLAN FROM WHICH PROJECT IS INCLUDED** | **PAGE NUMBER AND SECTION WHERE THE PROJECT, STRATEGY, ACTIVITY, OR SPECIFIC ACTION IS IDENTIFIED.** |
|---|---|
| e.g., MUSKEGON COUNTY COORDINATED HUMAN SERVICES/PUBLIC TRANSPORTATION PLAN | PAGE 4, CONTINUED FUNDING, ENHANCEMENT AND SUPPORT OF EXISTING PROGRAMS |

**How does project address an identified service gap or transportation coordination with public and/or private transportation and social service agencies? Please also identify those agencies**

THE PLAN NOTED ABOVE LISTS COMMUNITY TRANSPORTATION NEEDS ON PAGES 3 AND 4. REGIONAL CROSS COUNTRY SERVICE AND CONNECTIVITY FOR ALL AREAS WITH ACCESS TO MEDICAL SERVICES WERE IDENTIFIED AS MAJOR CONCERNS WHERE GAPS OCCUR. ONE MAJOR REASON IS TRANSIT OPERATORS ABILITY TO PROVIDE DOOR TO DOOR SERVICE FOR PERSONS WITH DISABILITIES AND SENIOR CITIZENS. THIS IS WHAT PIONEER PROVIDES WITH OUR ON DEMAND SERVICE. PIONEER TRANSPORTS INDIVIDUALS WITH DISABILITIES TO WORK SITES AND IS ONE OF THE ESTABLISHED PROVIDERS IN MUSKEGON COUNTY. AGENCIES INCLUDE: MATS, HEALTHWEST, HARBOR TRANSIT AND MAX TRANSIT

**Are there multiple providers for this project/service?** ○ Yes ◉ No

**Project Implementation Plan and Timeline.**

THIS PROJECT WILL BE IMPLEMENTED IN FY 2020

Michigan Department
Of Transportation
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# FY 2020 STATE CERTIFICATIONS AND ASSURANCES

**Form 1**

**This form is required for all agencies applying for Regular Services, Section 5311 JARC, Section 5310, and/or New Freedom projects.**

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**Name Of Applicant (legal organization name)**

MDOT Agency

THE APPLICANT AGREES TO COMPLY WITH THE APPLICABLE REQUIREMENTS SELECTED BELOW:

A. This organization has the necessary operational lifts on its vehicles as required by Act 51, [Section 10e (17) and 10e(18)] of the Public Acts of 1951, as amended, and the Americans with Disabilities Act of 1990. The organization also certifies that the lifts are maintained and cycled on a regularly scheduled basis. ☑

B. This organization has proof of insurance on file that meets the insurance requirements in exhibit a of your master agreement with the Michigan Department of Transportation. ☑

The applicant affirms the truthfulness and accuracy of the certifications and assurances it has made in statements submitted herein with this document. The truthfulness and accuracy of this document will enable the applicant to receive state funding.

Michigan Department
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# FY 2020 TITLE VI INFORMATION

**Name Of Applicant (legal organization name)**

MDOT Agency

All FTA funds recipients, except for urban agencies that receive all of their FTA funds directly from FTA, must submit the following information that covers the period since your last MDOT application. First-time applicants should submit information for the previous fiscal year.

**1. Are there any active lawsuits or complaints naming the applicant that allege discrimination based on race, color or national origin with respect to service or other transit benefits?**

○ Yes ◉ No

**2.Have you had any title vi compliance review activities conducted with regard to your transportation program, including triennial compliance reviews conducted by fta and/or mdot?**

◉ Yes ○ No

**Please summarize the purpose or reason for the review; the name of the agency or organization that performed the review; the findings and recommendations of the review; and a report on the status and/or disposition of such finding and recommendations.**

TRIENNIAL REVIEW ON 4/18/17 BY MDOT, NO FINDINGS OR RECOMMENDATIONS.

**3.When was your last title VI program approved by MDOT or FTA** 07/11/2017 **MM/DD/YYYY**

**4. Has your Title VI Coordinator/EEO Officer changed during the reporting period or since your last Title VI Plan was approved?**

◉ Yes ○ No

**Please provide the name and contact information for the new coordinator/EEO Officer**

Enter info here.

**5. Has your organization had any projects and/or service change that have Title VI, Limited English Proficiency (LEP), or Environmental Justice (EJ) impacts? Service change includes service expansion/ reduction, route and/or hour changes, etc**

○ Yes ◉ No

**6. During this reporting period, how were your employees educated about Title VI and their responsibility to ensure non-discrimination in any of your programs, services, or activities?**

ALL DRIVERS ARE TRAINED ANNUALLY. THEY ALL RECEIVE A COPY OF THE TITLE VI PLAN. THIS PLAN IS ALSO POSTED ON THE INTERNET AND IN EACH VEHICLE.

Michigan Department
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# FY 2020 VEHICLE ACCESSIBILITY PLAN UPDATE

**NOTICE: The Local Advisory Council(LAC) must review and be given the opportunity to comment on this Vehicle Accessiblity Plan (VAP). Please attach the signed minutes of the LAC meeting at which this VAP was discussed and approved.**

**Name Of Applicant (legal organization name)**

MDOT Agency

**1. Total D-R Fleet anticipated for application year (including locally funded vehicles)**

63

**2.Total Anticipated D-R Fleet Accessible or lift-equipped (including locally funded vehicles)**

61

**3. Has the agency made any changes in vehicle inventory described in No. 1 and No. 2 above since the last accessibility plan update was submitted?**
**(If "yes" explain changes and reasons for those changes below.)**

(●) Yes ( ) No

**Explain changes and reasons for those changes**

buses were retired and purchased

**4.Has the agency made any changes in the following since the last accessibility plan update was submitted?**

| | | |
|---|---|---|
| **A. Fare structure** | ( ) Yes | (●) No |
| **B. Service area information** | ( ) Yes | (●) No |
| **C. Service availability information** | ( ) Yes | (●) No |
| **D. Service Hours/days of operation** | ( ) Yes | (●) No |
| **E.Local advisory council membership** | ( ) Yes | (●) No |

**5.Has the agency made any other changes in its vehicle accessibility plan since last submission of an accessibility plan or annual update?**

( ) Yes (●) No

**6. Please indicate the number of times per year the agency's LAC meets**

( ) Annually (●) Quarterly ( ) Monthly ( ) Other

**7. LAC MEMBER LIST (List below the members of your agency LAC. Attach a separate page of additional names if necessary.)**

**NOTICE: The Local Advisory Council (LAC) must review and be given the opportunity to comment on this Vehicle Accessibility Plan (VAP). Please attach the signed minutes of the LAC meeting at which this VAP was discussed and approved.**

**NOTE: MDOT Administrative Rule 202 requires that the applicant agency shall establish a LAC composed of a minimum of three members. No LAC member shall be a staff or board member of the applicant agency. The applicant agency shall ensure all of the following:**
**1) 50% of the LAC membership represents persons who are 65 years of age or older and persons who have disabilities within the service area;**

**2) the LAC membership includes people who have diverse disabilities and the elderly who are users of public transportation; and**

**3) the applicant agency has approved at least one member, or 12% of the membership, jointly with the area agency on aging.**

**Does the list of members reflect the membership in the minutes?**

(●) Yes ( ) No

**1. CHAIR PERSON'S NAME**

Enter name

**Affiliation (Name of organization, if any)**

SENIOR RESOURCES

**This member represents**

- ○ Persons with Disabilities
- ◉ Persons 65 years and older
- ○ Neither of these groups

**This member is**

- ☑ Jointly appointed by an area agency on aging
- ☐ A user of public transportation
- ☐ None of these groups
- ☐ Age 65 or older
- ☐ A Person with Disabilities

**2. NAME**

Enter name

**Affiliation (Name of organization, if any)**

DAVITA DIALYSIS

**This member represents**

- ○ Persons with Disabilities
- ◉ Persons 65 years and older
- ○ Neither of these groups

**This member is**

- ☐ Jointly appointed by an area agency on aging
- ☐ A user of public transportation
- ☑ None of these groups
- ☐ Age 65 or older
- ☐ A Person with Disabilities

**3. NAME**

Enter name

**Affiliation (Name of organization, if any)**

DISABILITY NETWORK OF WEST MICHIGAN

**This member represents**

- ◉ Persons with Disabilities
- ○ Persons 65 years and older
- ○ Neither of these groups

**This member is**

- ☐ Jointly appointed by an area agency on aging
- ☐ A user of public transportation
- ☐ None of these groups
- ☐ Age 65 or older
- ☑ A Person with Disabilities

**4. NAME**

**Affiliation (Name of organization, if any)**

**This member represents**

- ○ Persons with Disabilities
- ○ Persons 65 years and older
- ○ Neither of these groups

**This member is**

- ☐ Jointly appointed by an area agency on aging
- ☐ A user of public transportation
- ☐ None of these groups
- ☐ Age 65 or older
- ☐ A Person with Disabilities