



The State of Nevada Department of Transportation
Multimodal Planning, Transit Office

OPERATING ASSISTANCE ADDENDUM

For Program Administration Assistance (PAG),
Capital Maintenance Assistance (CPG),
Mobility Management Program Assistance (CPG), or
Operating Assistance (OPG)
under FTA §5311 Program

(must be accompanied by FEDERAL GRANT APPLICATION)

for FEDERAL FISCAL YEAR 2021
(10/01/20 thru 09/30/21)

For additional information or assistance, please contact the Transit Office at
775-888-7312 or transitteam@dot.nv.gov

INTRODUCTION

The Nevada Department of Transportation (Nevada DOT) is the agency designated to apply for, receive, and administer funds under Federal Transit Administration (FTA) Section 5311. This Operating Assistance Addendum has been developed to assist applicants in applying for Program Administration Assistance (PAG), Capital Maintenance Assistance (CPG), Mobility Management Program Assistance (CPG), and/or Operating Assistance (OPG) or Intercity Assistance (ICG) under this program.

Program Administration Assistance (PAG)

Available under the **§5311 Program** at up to 80% federal assistance with a minimum 20% local match.

Capital Maintenance Assistance (CPG)

Available under the **§5311 Program** at up to 95% federal assistance with a minimum 5% local match.

Mobility Management Program Assistance (CPG)

Available under the **§5311 Program** at up to 95% federal assistance with a minimum 5% local match.

Operating Assistance (OPG)

Available under the **§5311 Program** at up to 59.38% federal assistance with a minimum 40.62% local match.

Intercity Assistance (ICG)

Available under the **§5311(f) Program** at up to 59.38% federal assistance with a minimum 40.62% local match.

1. Program Description

Provide a detailed description of your agency mission and objectives. *Minimum 100 characters.*

Performance data and service descriptions will be collected on subsequent pages.

Performance Data for Applicant Agency

Applicants must enter all historical data for the modes that they operated in the indicated federal fiscal year, even if that mode is not currently in operation.

All Modes	Vehicle Revenue Miles (VRM)	Vehicle Revenue Hours (VRH)	Unlinked Passenger Trips (UPT)	Operating Expenses	Fare Revenues
2018					
2017					
2016					
2015					
2014					

DR	Operating Expenses per VRM	Operating Expenses per VRH	Operating Expenses per UPT	Unlinked Trips per VRM	Unlinked Trips per VRH
2018					
2017					
2016					
2015					
2014					

MB	Operating Expenses per VRM	Operating Expenses per VRH	Operating Expenses per UPT	Unlinked Trips per VRM	Unlinked Trips per VRH
2018					
2017					
2016					
2015					
2014					

CB	Operating Expenses per VRM	Operating Expenses per VRH	Operating Expenses per UPT	Unlinked Trips per VRM	Unlinked Trips per VRH
2018					
2017					
2016					
2015					
2014					

2. Program Objectives

Describe how your program mission and objectives align with the goals in the 2018 Coordinated Human Services Transportation Plan (CHSTP) for providing enhanced mobility to seniors and individuals with disabilities.
Minimum 100 characters.

3. Service Description

For each item, indicate the service(s) currently being provided, as well as any proposed service area or scheduled expansion and the populations served. Indicate if the mode is *Directly Operated* or *Purchased Transportation*.

Demand Response (DR)

N/A

DO or PT

Description of services, including service areas and vehicle quantities and types. *Minimum 50 characters.*

Detailed description of service schedule(s). *Minimum 50 characters.*

How was the need determined for this service, or expansion of services? *Minimum 50 characters.*
ex: determined by governing board, community outreach, planning study, etc.

Fixed Route, including Deviated Fixed Route (MB)

N/A

DO or PT

Intercity Bus (*check if your MB is an intercity route*)

Description of services, including service areas and vehicle quantities and types. *Minimum 50 characters.*

Detailed description of service schedule(s). *Minimum 50 characters.*

How was the need determined for this service, or expansion of services? *Minimum 50 characters.*
ex: determined by governing board, community outreach, planning study, etc.

Description of services, including service areas and vehicle quantities and types. *Minimum 50 characters.*

Detailed description of service schedule(s). *Minimum 50 characters.*

How was the need determined for this service, or expansion of services? *Minimum 50 characters.*
ex: determined by governing board, community outreach, planning study, etc.

Commuter Bus

N/A

DO or PT

Intercity Bus (*check if your CB is an intercity route*)

Description of services, including service areas and vehicle quantities and types. *Minimum 50 characters.*

Detailed description of service schedule(s). *Minimum 50 characters.*

How was the need determined for this service, or expansion of services? *Minimum 50 characters.*
ex: determined by governing board, community outreach, planning study, etc.

Mobility Management

N/A

Description of mobility management services and activities, including the service area and position titles of staff members. *Minimum 50 characters.*

How do your proposed activities align with the recently published 2018 CHSTP? *Minimum 50 characters.*

How do mobility managers assist in meeting the goals of transit operators in the region? *Minimum 50 characters.*

Mobility Management (continued)

How was the need determined for mobility management in this region/area? *Minimum 50 characters.*
ex: determined by governing board, community outreach, planning study, etc.

Will the mobility manager have responsibilities unrelated to mobility management? If yes, detail these responsibilities.

If yes, how does this impact the agency or mobility management budget?

4. Program Justification

What justification exists for the continuation of these services in FFY2021? *Minimum 100 characters.*

5. Schedule

Provide a detailed schedule for each mode of service or agency activity. *Minimum 100 characters.*

Mobility Management Program applicants should provide a schedule and description of all mobility manager and non-mobility manager activities.

6. Directly Operated (DO) and/or Mobility Management Program Oversight

If your agency provides directly operated transit or mobility management services, describe the program oversight activities used by your agency or governing board in the regular monitoring of your program. Include information about performance reviews, reports, and corrective action plans. *Minimum 100 characters.*

7. Purchased Transportation (PT) Program Oversight

If your agency provides purchased transportation through a third-party operator, describe the program oversight activities used by your agency or governing board in the regular monitoring of the third-party. Include information about performance reviews, reports, and corrective action plans. *Minimum 100 characters.*

Please provide the information for your third-party operator.

(3 rd Party Contract) Entity Legal Name:	
Physical Address, City, State ZIP:	
Mailing Address, City, State, ZIP:	
3 rd Party Contact Name and Title:	
Phone Number:	Fax Number:
E-Mail Address:	

8. Coordination Efforts

Describe your agency coordination efforts with other transit agencies and mobility managers, including the frequency of communication. Are schedules developed and routes executed to facilitate connections to neighboring transportation providers? How are regional trips accommodated? What information is exchanged during these efforts? *Minimum 100 characters.*

9. Budget Justification

Please describe how your budget was developed, including your consideration of your agency's spending trends and any expected budget buffers, or "padding", that may have been included in the budget by increasing projected expenses or reducing expected revenues to account for economic fluctuations in the project. *Minimum 50 characters.*

Each line item of the proposed budget should be explained, in detail, for review by the Transit Office. Indicate if the budget has increased or decreased from any previous application. Please describe how the increase/decrease in your budget request will maintain, or improve upon, the current levels of service you provide.

Attach the *Operating Budget Form* to this addendum.

10. Additional Information

Please provide any additional information for consideration of your application for operating funding assistance.
ex: project performance, prior issues that have been addressed or resolved, service constraints, future service considerations, etc.

STATEMENT OF ACCEPTANCE OF THE SPECIAL SECTION 5333(b) WARRANTY

All Section 5311 Applicants must execute the following statement of acceptance:

(APPLICANT)

and

(RECIPIENT/CONTRACT PROVIDER, IF NOT APPLICANT)

Agree to make use of the Special Section 5333(b) Warranty developed for exclusive application to the Rural and Small Urban Transit Assistance Program – Section 5311 of the Federal Transit Act, as amended.

The Applicant and Recipient/Contract Provider agree to be bound by the terms and conditions of the Special Section 5333(b) Warranty for its pending Section 5311 assistance grant. This warranty shall become a part of any contract between the Nevada DOT and the applicant.

Authorized Signature

Date

Authorized Signature of Recipient/Contract Provider

Date

Mailing Address of Agency Posting this Notice:	
City:	State: Zip Code:
Phone Number:	Fax Number:
E-Mail Address:	

SPECIAL SECTION 5333(b) WARRANTY

This form must be completed by all Applicants.
If there are no other eligible providers in your service area, mark a "N/A" under the Other Eligible Providers section.

(APPLICANT)

(UNION REPRESENTATIVE)

Service Area Description:

Operating Assistance for FY 2020

Capital Assistance to purchase: _____

Recipients/Contract Provider (if different from applicant) and Union Representation (Union & Local #):

- 1. _____
- 2. _____
- 3. _____

Other Eligible Providers in Service Area and Union Representation (Union & Local #):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

FTA requires that each subrecipient (or contract provider) of Section 5311 funding must post the Special Section 5333(b) Warranty (this page) where affected employees may see it.

OPERATING ASSISTANCE ADDENDUM ATTACHMENTS

Attachments to this addendum are as follows:

Operating Budget Form

Certificate of Insurance

Letters of Support *(not required)*