

2006 CAPITAL DISTRICT HEALTH & HUMAN SERVICES TRANSPORTATION SURVEY

This survey is divided into three parts and primarily contains check off boxes to help minimize the time needed for completion. Part I should be completed by all respondents and asks general questions about your consumers and their transportation needs. Parts II and III should be completed by respondents who provide transportation services to consumers.

If you have any questions about the survey or how to complete it, please contact Deborah Stacey at the Capital District Transportation Committee (CDTC) at 458-2161 or by email at rtcc@cdtempo.org.

Completed surveys are due by **November 13, 2006**. Please mail the entire survey package (including any uncompleted sections) using the return self-stamped envelope provided.

Important: All answers provided in this survey are for informational purposes only. Answers provided will not be shared with enforcement or regulatory entities, except as part of aggregate, anonymous data reports and analyses.

PART I

ORGANIZATION INFORMATION & GENERAL TRANSPORTATION NEEDS

(THIS PART SHOULD BE COMPETED BY ALL RESPONDENTS RELATED TO ALL CONSUMERS OF THE ORGANIZATION, NOT JUST THOSE RECEIVING TRANSPORTATION ASSISTANCE)

Organization Name: _____

Address: _____

City: _____ Zip Code: _____

Organization Phone: _____ Organization Fax: _____

Website url: http:// _____

Contact Person: _____ Contact Phone: _____

Contact Email: _____

1. What age group(s) does your organization serve? (Check all that apply)

Children/Youth ages 0-12

Seniors ages 60+

Adolescents ages 13-17

Other: _____

Adults ages 18-59

2. What special needs subgroups does your organization serve? (Check all that apply)

Persons with mental illness

Pre-school/school-aged children with varied disabilities

Persons with developmental disabilities

Persons with physical disabilities

Persons with alcohol/substance abuse

Low income/Public Assistance

Persons with medical problems

Other: _____

3. In which Capital District county(ies) do your organization's consumers reside? (Check all that apply)

Albany

Saratoga

Schenectady

Rensselaer

4. **What percentage of your consumers do you estimate have transportation limitations?** _____%
("Transportation limitation" is any physical, developmental, mental, economic or other condition(s) that limits a person's ability or causes difficulty in getting to places to which they need or want to go.)

4a. **Of those consumers identified in question 4, please estimate the percentage that have the following types of transportation limitations:**

- ____ % Age-related disability
- ____ % Physical disability
- ____ % Financial limitations (e.g. cannot afford vehicle or public transit)
- ____ % Lives in remote location
- ____ % Developmental disability
- ____ % Mental Health disability
- ____ % Visual impairment
- ____ % Hearing impairment
- ____ % Other: _____

N/A - None of our customers have transportation limitations

4b. **Of those consumers identified in question 4, please estimate the percentage who need special equipment or assistance:**

- ____ % Wheelchair lifts
- ____ % Car seats
- ____ % Personal Care Attendant/Escort
- ____ % Assistance getting in/out of vehicle
- ____ % Location call outs/Navigation assistance for visually impaired
- ____ % Other: _____
- ____ % Unsure of special equipment or assistance needs

5. **Does your organization specifically dedicate staff or volunteers, either full or part time, to providing consumers with trip planning or travel training assistance?** Yes No

6. **Approximately what percent of your consumers arrange for their own transportation?** _____%

6a. **Do you reimburse these clients for travel expenses?** Yes No

6b. **If yes, approximately how many total trips do you reimburse per week on average?** _____

7. **Please describe briefly the primary concern(s) that you have regarding the provision of transportation services to persons with transportation limitations:**

Please Continue to Part II on the Next Page

PART II:

TRANSPORTATION SERVICE INFORMATION

(THIS PART SHOULD BE COMPLETED BY RESPONDENTS THAT DIRECTLY PROVIDE OR PURCHASE TRANSPORTATION ASSISTANCE FOR CONSUMERS)

8. What kind of transportation assistance does your organization provide to your consumers? (Check all that apply)

- Direct Transportation (Check all forms of direct transportation that apply):
 - Organization owned/leased cars
 - Organization owned/leased vans/buses
 - Personal vehicles driven by employees (Check here if you provide cash reimbursement to staff for consumer-related travel)
 - Personal vehicles driven by volunteers (Check here if you provide cash reimbursement to volunteers for consumer-related travel)
- Transportation Purchased (Check all forms of purchased transportation that apply):
 - Contract with another organization for transportation
 - Other purchased arrangements (specify): _____
- Provide CDTA Swiper Pass/Tokens
- Provide cash reimbursement to consumers for transportation
- We do not provide assistance with transportation (**STOP - You do not need to complete the rest of the survey**)
- Other: _____

9. During 2005, how many one-way passenger trips per week did you provide or arrange on average? (Each passenger pick up and drop off is counted as a one-way passenger trip) _____

9a. Please estimate the percentage of the total one-way trips that were provided Monday – Friday: _____%

10. Do you restrict the use of your transportation assistance only to consumers of your own organization's programs and services? Yes No

10a. If yes, is the restriction an agency policy or funding source restriction?

10b. Please briefly explain the restriction:

11. Please identify the purposes of your organization's transportation assistance:

- | | |
|---|---|
| <input type="checkbox"/> Treatment Program Attendance | <input type="checkbox"/> Government income/support agencies (e.g. DSS, Social Security, etc.) |
| <input type="checkbox"/> Social/Recreational Programs | <input type="checkbox"/> Legal assistance agencies |
| <input type="checkbox"/> Medical-related appointments/services | <input type="checkbox"/> Criminal justice/court activities and appointments |
| <input type="checkbox"/> Employment-related (e.g. job, interviews, training, etc.) | <input type="checkbox"/> Groceries/Shopping/Personal business |
| <input type="checkbox"/> Education-related (e.g. school, vocational programs, etc.) | <input type="checkbox"/> Congregate Meals |
| | <input type="checkbox"/> Other: _____ |

12. Please indicate the type of transportation your organization either directly provides or purchases. (Check all that apply)

- CDTA Tokens/Swipers
- Fixed Route (prescribed routes and fixed schedules)
- Demand Response (consumer requests services when needed)
- Recurring Trips (consumer-specific, recurring patterns of pick-up/destination, time and days of week)
- Special Events (transportation for the specific purpose of customers getting to/from a special events)

13. Is the transportation you provide restricted geographically by:

- County? If so, which county(ies) do you serve? Albany Saratoga Schenectady Rensselaer
 Municipality? If so, which municipalities do you serve? _____

Geographic radius? < 25 miles 25 - 35 miles 36 - 50 miles > 50 miles

Zip Code? If so, which zip codes? _____

The remainder of the questions in this part (questions 14 – 31) are to be completed by organizations that own or lease vehicles. If your organization does not own or lease vehicles to provide transportation, please skip to Part III, question 32.

14. To what age group(s) does your organization provide transportation? (check all that apply)

- Children/Youth ages 0-12 Seniors ages 60+
 Adolescents ages 13-17 Other: _____
 Adults ages 18-59

15. To what special needs subgroups does your organization provide transportation? (check all that apply)

- Persons with mental illness Pre-school/school-aged children with varied disabilities
 Persons with developmental disabilities Persons with physical disabilities
 Persons with alcohol/substance abuse Low income/Public Assistance
 Persons with medical problems Other: _____

16. Please estimate the percentage of the passengers your organization transports who require special equipment or assistance.

- ____% Wheelchair lifts
____% Car seats
____% Personal Care Attendant/Escort
____% Assistance getting in/out of vehicle
____% Location call outs/Navigation assistance for visually impaired
____% Other: _____
____% No special equipment or assistance provided

17. Please estimate the percentage of all trip requests denied or cancelled by your organization in the past year for the following reasons.

- ____% Customer ineligible
____% Request outside geographic service area
____% Request outside scope of organization's transportation services
____% Request outside of standard vehicle availability/schedule
____% Insufficient capacity to accommodate volume of requests
____% Inability to adequately accommodate customer's special needs
____% Other: _____
 We have not denied trip requests during the past year

18. How do you maintain your vehicle fleet? (Check all that apply)

- Vehicle maintenance performed in-house
 Vehicle maintenance contracted to outside vendor
 Other (please specify) _____

19. For vehicle scheduling, dispatching and communications with and between vehicles during their routes, do you use: (Check all that apply)

- Two-way radio
- Cell phones
- Computer scheduling software (please specify) _____

- Other: _____
- We do not use scheduling, dispatching or communication tools or equipment

20. Who normally drives your organization's vehicles to provide transportation services for customers? (Check all that apply)

- Volunteers
- Staff hired specifically to be drivers

- Other staff
- Other: _____

20a. Approximately how many drivers does your agency use per day to provide transportation services to customers? _____

21. Are employees and volunteers who serve as drivers for your organization required to comply with special training, certifications or other regulations under the New York State Department of Motor Vehicles, such as having a Commercial Drivers License (CDL)? Yes No

22. Please provide the following information for all of the transportation-related training that your organization provides to your employee and volunteer drivers:

Type of Training	Who Receives Training? (volunteers, driver staff, non-driver staff)	Annual Hours	Mandated? (Check if training is mandated by regulation)

23. Are you required to comply with New York State Department of Transportation (DOT) vehicle inspections? Yes No

24. Please indicate if you are currently experiencing any of the following challenges in operating your transportation program. (Check all that apply)

- Unfamiliar/inexperienced with DOT regulations
- Difficulty complying with DOT vehicle regulatory standards
- Difficulty accessing/setting up DOT inspection
- Difficulty recruiting and retaining qualified drivers
- Difficulty finding/accessing driver training
- Difficulty finding reliable/quality maintenance and repair services
- Difficulty obtaining affordable transportation-related insurance
- Difficulty securing adequate funding for providing/operating transportation services
- Inadequate number of vehicles owned to meet demand
- Inability to adequately fill customer transportation needs due to vehicle maintenance and repair needs and/or lack of backup vehicles
- Other (please specify) _____

25. Do you have under-utilized transportation capacity? Yes No

If yes, how frequently? Often Sometimes Rarely

25a. Do you experience vehicle downtime not related to maintenance or inspection? Yes No

If yes, how frequently? Often Sometimes Rarely

25b. Is your organization's under-utilized transportation capacity and/or non-maintenance related vehicle downtime predictable? Yes No Not Applicable

26. Does your organization participate in transportation coordination programs and efforts? (Check all that apply)

- Share vehicles with another organization
- Share a pool of volunteer or hired drivers with another organization
- Coordinate vehicle routes/schedules with another organization and/or transport non-organization customers
- Share transportation scheduling and dispatching efforts and resources
- Shared provision or joint purchase with another organization of vehicle maintenance services
- Joint contract or purchase for bulk fuel
- Other: _____
- We do not currently participate in transportation coordination programs and efforts

27. Do you provide transportation to other organizations' consumers? Yes No

If yes, please name the other organization(s): _____

27a. Please indicate the structure used for these coordination arrangement(s): (Check all that apply)

- Contract or Memorandum of Understanding with another organization(s)
- Revenue/reimbursement received from other organization for transportation provision
- Passenger from other organization pays for transportation provided
- Other: _____

28. Is your organization interested in serving on a task force that would investigate coordination options for human service transportation? Yes No Unsure

29. Is your organization interested in having its transportation services information included in a future directory of human services transportation services? Yes No Unsure

30. Looking toward the next five-year period, please estimate the number of vehicles you will need for expansion or replacement purposes.

Vehicle Type	# of Vehicles for Replacement	# of Vehicles for Expansion
Buses		
Vans		
Cars		
Trucks/SUV		
Other: _____		

Please Complete the Vehicle Roster on the Next Page

2006 CAPITAL DISTRICT HEALTH & HUMAN SERVICES TRANSPORTATION SURVEY – PART II (CONTINUED)

31. Please complete the vehicle roster chart for all of your organization’s owned and leased vehicles. Do not include staff or volunteer owned vehicles that may be used to provide transportation to consumers. This information is being collected to assess the overall condition of our community’s entire fleet of vehicles, as well as to identify potential opportunities for coordination by understanding total fleet size and capacity.

Current Vehicle Roster

Vehicle	Model Year	Vehicle Type Bus, Van, Car, Truck/SUV, or Other (if Other, please specify)	Passenger Capacity	Vehicle Condition Excellent, Good, Fair, or Poor	# of Wheelchair positions	Wheelchair Access Lift, Ramp, None or Other (if Other, please specify)	Vehicle Use Status Active, Spare or Inactive	Annual Mileage (if known)
#1								
#2								
#3								
#4								
#5								
#6								
#7								
#8								

This page may be copied for agencies with more than 8 vehicles. For additional pages, please continue the vehicle numbering sequence (e.g. 9, 10, 11, etc.)

PART III
TRANSPORTATION FINANCIAL INFORMATION

Purpose: To fully understand our community's human services transportation system, it is important to know about the fiscal resources dedicated to transportation. The following questions request information relating to the 2005 fiscal year (January 1, 2005 – December 31, 2005). If your organization follows a different fiscal year calendar, please indicate such below and provide information for the most recent fiscal year completed.

Reminder: The answers provided in this survey are for informational purposes only. *Answers will not be shared with enforcement or regulatory entities, except as part of aggregate, anonymous data reports and analyses.*

Indicate Fiscal Year Reported: 2005 Other: _____

32. For the fiscal year indicated above, please estimate the total amount your organization expended to provide transportation services: \$ _____

32a. Please list the types of expenses included in the above total (e.g. wages and benefits, equipment and vehicle costs, insurance, mileage reimbursement, maintenance, facility overhead, driver drug tests, training, purchased transportation services, etc)

Check here if your organization is unable to estimate the total amount expended annually to provide transportation services.

32b. Please estimate the total amount your organization expended in the fiscal year indicated above for the following transportation-related items:

Total annual fuel costs	\$ _____
Total maintenance costs	\$ _____
Total insurance costs	\$ _____

33. Does your organization receive funding that is restricted to the provision of transportation assistance?

Yes No

If yes, please specify the funding source(s):

34. Does your organization's budget have a specific line item(s) for transportation-related services?

Yes No

Thank you for completing the 2006 Capital District Health & Human Services Transportation Survey. The information you provided will greatly assist the Regional Transportation Coordination Committee in their efforts to analyze the current transportation system, as well as to identify needs and opportunities for enhanced coordination and service delivery.