METRO RTA
416 Kenmore Blvd.
Akron, OH 44301
PH (330)376-5353
FAX (330)564-2230
www.akronmetro.org

For Office Use Only:
Expiration Date:
Photo on file? Y / N
METRO ID:

APPLICATION FOR SCAT TEMPORARY SERVICES

PART A: ALL APPLICANTS MUST COMPLETE THIS SECTION IN ITS ENTIRETY. PLEASE PRINT.					
1.	Last Name:		2.	First Name: MI:	
3.	Address:				
4.	City/State:		5.	Zip Code:	
6.	Home Phone #:	7.	Cell Phone #:	8.	Date of Birth:
9.	Emergency Contact and Relationship:		10.	Emergency Contact Phone:	
11.	Signature of Applicant:			12.	Date:

By signing and submitting this application, you are giving consent to METRO RTA to contact your medical professional to verify the information contained within this application.

PART B: ALL APPLICANTS MUST COMPLETE THIS SECTION IN ITS ENTIRETY. PLEASE PRINT.					
13.	Can you ride line service/fixed route buses for some trips?	☐ Yes	☐ No		
14.	Do you need a METRO photo ID?	☐ Yes	☐ No		
15.	What type of transportation have you used in the past?				
	What type of transportation do you use now?				
16.	If you cannot ride the regular line service bus, please describe the disability that prevents you from using METRO line service:				
17.	Are you able to get to the SCAT vehicle without assistance? ☐ Yes ☐ No		18.	Can a SCAT bus turn around in your driveway? ☐ Yes ☐ No	

SCAT services are for residents of Summit County provided within Summit County.
Applicants will be required to submit proof of residency in order to qualify for services.

PART C: TO BE COMPLETED BY APPLICANTS USING MOBILITY AID(S).				
19.	What type of mobility aid do you use:	☐ Scooter	☐ Walker	☐ Cane
	☐ Standard Wheelchair	☐ Electric Wheelchair		
	☐ Other: _____			
20.	Do you have a Ramp at home? ☐ Yes ☐ No		21.	Any other information regarding your mobility device?

In order to complete the application process, you may be required to complete a mobility device assessment. Please note that all METRO Line Service/Fixed Route and Parartransit vehicles are 100% accessible.

This application must be filled out completely to be considered for service. Incomplete applications will be returned to the applicant or medical professional. As a part of the application process, you may be required to participate in an assessment to determine your eligibility.

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Applicant's Last Name:	Applicant's First Name:

PART D: TO BE FILLED OUT BY MEDICAL PROFESSIONAL (PLEASE PRINT LEGIBLY).
APPLICATIONS WILL BE REJECTED IF ANY AREA OF PART D IS FILLED OUT BY APPLICANT.
For more info on the application process, call 330-376-8458 or go to www.akronmetro.org/metro-scat.aspx

22.	Give a detailed description of disability/impairment, and how it prevents your client from riding line service/fixed route:
23.	This certification is for (trip type requests are subject to availability of other services): ☐ Medical Appointments ☐ Work* ☐ Higher Education* ☐ Grocery * VERIFICATION OF EMPLOYMENT AND/OR HIGHER EDUCATION MUST BE PROVIDED BY APPLICANT TO SECURE SERVICE
24.	Is this disability permanent? ☐ Yes ☐ No If no, what is the anticipated duration (in months)? _____
25.	Please check all that apply to the applicant: ☐ No disability which prevents the use of accessible regular line/fixed route buses ☐ Able to walk independently ☐ Able to walk, negotiates changes in grades with difficulty/insecurity ☐ Able to walk, negotiates grade changes with difficulty/insecurity and uses a mobility device ☐ Visual or auditory condition that causes difficulty or insecurity ☐ Mental or psychological condition that causes difficulty or insecurity ☐ Unable to walk, able to use a wheelchair independently ☐ Unable to walk or make use of a wheelchair without assistance ☐ Other: _____
26.	I recommend this individual for the following METRO service and is **public transit appropriate**: ☐ SCAT origin to destination temporary service. ☐ METRO line service/fixed route Reduced Fare program. ☐ I do not recommend this individual for service at this time.

I, the undersigned medical professional, certify that the above mentioned client is prevented from accessing METRO fixed route/line service due to disability/impairment and should be considered for SCAT Temporary origin to destination services. By signing this, you agree to the validity of the information presented in this application.

Printed Name: _____

License # or ID #: _____ Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Signature:_____ Date:_____

Knowingly providing fraudulent information on this application may result in loss of current and/or future service.

LARGE PRINT AND ACCESSIBLE APPLICATION AVAILABLE ON REQUEST

This application must be filled out completely to be considered for service. Incomplete applications will be returned to the applicant or medical professional. As a part of the application process, you may be required to participate in an assessment to determine your eligibility.

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