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?	Υ	/	Ν	
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:			1	MI:
3.	3. Address:									
4.	City/State:			5.	Zip C	ode:				
6.	Home Phone #:	7. Cel	l Pho	ne #:	•		8.	Date o	f Birth:	
9.	Emergency Contact and Relationship:				10.	Emerg	ency C	ontact F	hone:	
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 MUS	ST COMP	LETE	THIS	SECTIO	N IN ITS	ENTIR	ETY. PL	EASE P	RINT.
13.	Can you ride line service/fixed i	route bus	ses fo	r som	e trips ?)		Yes		No
14.	Do you need a METRO photo ID)?						Yes		No
15.	What type of transportation have you used in the past?									
10.	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 without assistance? Yes	vehicle		18.	Can a S		turn a	round ir	n your d	riveway? 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 CON									
	What type of mobility aid do yo			Scoot			Walker		Cane	
19.	☐ Standard Wheelchair		☐ Electric Wheelchair							
	□ Other:									
	Do you have a Ramp at home?			de	Any other information regarding your mobility device?					
20.	□ Yes □	No	21.							
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. REV 11/16

	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						
21.	Give a detailed description of disability/impairment, and how it prevents your client from riding line service/fixed route:						
22.	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						
23.	Is this disability permanent? If no, what is the anticipated duration (in months)? No						
24.	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:						
25.	I recommend this individual for the following METRO service and is <u>public transit appropriate</u> : □ 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.						
acce SCA	e undersigned medical professional, certify that the above mentioned client is prevented from essing METRO fixed route/line service due to disability/impairment and should be considered for T Temporary origin to destination services. By signing this, you agree to the validity of the rmation presented in this application.						
	ted Name:						
	License # or ID #: Agency:						
	ress:						
	/State/Zip:						
	ne:Fax:						
	ature: Date:						

Applicant's First Name:

Applicant's Last Name:

LARGE PRINT AND ACCESSIBLE APPLICATION AVAILABLE ON REQUEST

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REV 10/16