ADA PARATRANSIT ELIGIBILITY CERTIFICATION FORM

Office Use Only

Name ________________________
ID # ________________________
Exp. Date _____________________
PID Exp. Date _________________
PCA □ yes □ no
Eligibility _____________________
Conditional □
Unconditional □
Comments ___________________
______________________________
______________________________
______________________________

METRO RTA Paratransit Services
416 Kenmore Blvd. | Akron, Ohio | 44301
Phone: 330.762.0341
Fax: 330.564.2230
yourmetrobus.org

Revised January 2024
PART I: GENERAL INFORMATION TO BE COMPLETED BY APPLICANT (PLEASE PRINT OR TYPE)

Last Name                                    First Name                                   Middle Initial

☐ Male ☐ Female ☐ Prefer Not to Say

Date of Birth

Street Address

Building/Apt. #  Apartment Name

City/Town                                                State                                         Zip

Primary Phone                                          Secondary Phone

If you have a METRO ADA Paratransit ID Card, please provide the ID #:

PART II: INFORMATION ON DISABILITY AND MOBILITY EQUIPMENT

1. How does your disability prevent you from using METRO’s bus services?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

2
2. Is your disability permanent?
   □ Yes
   □ No
   If no, expected duration of your disability: _____/_____/

3. Have you ever had a seizure?
   □ Yes
   □ No
   If yes, what type? __________________________ How often? ________________
   Are your seizures controlled with medication?
   □ Yes
   □ No

4. Do you use any of the following mobility aids? (Check all that apply.)
   □ Manual wheelchair  □ Cane
   □ Powered wheelchair  □ Braces
   □ Powered scooter     □ Service animal
   □ Prosthesis         □ Personal care attendant
   □ Walker            □ Other:
   □ Crutches

PART III: QUESTIONS ON USING THE BUS

1. Have you ever used METRO’s bus services?
   □ Yes
   □ No
2. Have you participated in METRO’s reduced fare program? (i.e. older adults or those with disabilities)
   ☐ Yes
   ☐ No

3. Does your medical condition change from day-to-day, where it may be difficult to use bus services?
   ☐ Yes, my physical condition is good on some days and bad on others
   ☐ No, my physical condition does not change from day-to-day
   ☐ Not sure
   ☐ Other reasons ________________________________

4. On days when your physical condition is good, can you, on your own or using a mobility aid:
   ☐ Get to the curb in front of your house
   ☐ Travel up to one (1) block
   ☐ Travel up to four (4) blocks
   ☐ Travel up to six (6) blocks
   ☐ Can’t travel outside your house; please explain:

   ___________________________________________________________

5. On days when your physical condition is bad, can you, on your own or using a mobility aid:
   ☐ Get to the curb in front of your house
   ☐ Travel up to one (1) block
   ☐ Travel up to four (4) blocks
   ☐ Travel up to six (6) blocks
   ☐ Can’t travel outside your house; please explain:

   ___________________________________________________________
6. Does the weather have an effect on your ability to use bus services?

☐ Yes
☐ No
☐ I don’t know

If yes, how does the weather affect your ability to use bus services?

_____________________________________________________________________

_____________________________________________________________________

7. Are you currently using METRO’s bus services?

☐ Yes
☐ No

If yes, what routes? ___________________________________________________________________

8. Can you transfer from one bus to another?

☐ Yes
☐ No, please explain: ___________________________________________________________________

9. Are you able to, on your own, use the telephone to obtain bus information?

☐ Yes
☐ No, please explain: ___________________________________________________________________

10. Are you able to follow written or oral instructions to use bus services?

☐ Yes
☐ No, please explain: ___________________________________________________________________
11. Can you, without the assistance of another person, get to or from the bus stop nearest your home?

☐ Yes
☐ Not sure
☐ No, please explain: _____________________________________________
_________________________________________________________________

12. Can you wait ten (10) minutes at a bus stop that has a seat and a shelter?

☐ Yes
☐ Not sure
☐ No, please explain: _____________________________________________
_________________________________________________________________

13. Can you wait ten (10) minutes at a bus stop that does not have a seat and a shelter?

☐ Yes
☐ Not sure
☐ No, please explain: _____________________________________________
_________________________________________________________________

14. Are you able to get on and off a bus if it had a mobility device lift?

☐ Yes
☐ Not sure
☐ No, please explain: _____________________________________________
_________________________________________________________________
15. Are you able to follow written/oral instructions to pay your bus fare?

☐ Yes

☐ No, please explain: _____________________________________________
_____________________________________________________________________

16. Are you able to recognize when it is time to get on and off the bus?

☐ Yes

☐ Not sure

☐ No, please explain: _____________________________________________
_____________________________________________________________________

PART IV: QUESTIONS ABOUT TRAINING

Travel training may be available to persons with disabilities who may be able to use accessible bus transportation. Travel training may be offered to familiarize customers with general public transit, specific routes, and bus stops. Training for bus services does not make you eligible for Paratransit Services.

1. Have you ever received training on how to use a bus?

☐ Yes

☐ No

If yes, please check all the skills you have learned:

☐ General bus travel

☐ Getting to and from bus stops

☐ Getting on and/or off a bus

☐ What to do in an emergency situation

☐ How to transfer to a different bus

☐ How to read a bus schedule

☐ How to use the fare box
2. Did you complete the training?

☑ Yes
☐ No, please explain: ____________________________________________________________
______________________________________________________________________________

3. Would you be interested in receiving training/retraining for METRO’s bus services?

☐ Yes
☐ No

PART V: YOUR CURRENT TRAVEL

List your 3-4 most frequent destinations and how you get there now:

<table>
<thead>
<tr>
<th>Destination address</th>
<th>Frequency of travel</th>
<th>How you get there</th>
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Please read the following statements and check those that best describe what you believe is your ability to use METRO bus services without assistance. You may select more than one.

When are you unable to independently use METRO bus services?

☐ I can use METRO bus services for some trips, but not other times because there are barriers that prevent me from using the system.

☐ I use the bus frequently.

☐ I have difficulty understanding and remembering all of the things that I would have to do to find my way to and from the bus.

☐ I believe I could learn to ride the bus, if someone taught me.

☐ I have difficulty or cannot climb stairs and can only board a METRO vehicle if it has a lift.

☐ I have a visual disability that prevents me from getting to and from the bus, even with training.

☐ The severity of my disability can change from day-to-day. I can ride the bus only when I am feeling well.

☐ I can never use the bus by myself.

☐ I can get to and from the bus if the distance is not too great and the route is barrier-free.

☐ I am not able to use the bus for other reasons. Please explain:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
Physician Verification Form
Paratransit Services

Date: ______________________________

Patient Name: _______________________________________________________

The person named above is ___ currently being treated or ___ was formerly treated by me. The person has informed me of his/her/their intent to apply for METRO RTA ADA services. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using METRO’s bus services.

The following information confirms the patient’s disability.

Diagnosis/Disability: Date of Onset: ______________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Prognosis: ___________________________________________________________

Disability Status (Select one):

☐ Patient’s disability is temporary.

☐ Patient’s disability is permanent.

My signature below certifies that the above information is accurate.

_____________________________________________________________________

Physician signature and credentials (M.D, D.O.)*

Print physician name and credentials

License # ____________________________
Address ____________________________
City ________________________________
State ______________________________
Zip __________________________________
Physician’s Office Phone Number ______________________________________

*Must be signed by a licensed physician.

I, ______________________________________ hereby verify that the diagnosis of disability listed above has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named on this form.

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ONCE METRO RECEIVES THE COMPLETED PRESCRIPTION AND THE ADA APPLICATION, WE WILL CONTACT YOU.

Paratransit Evaluation Prescription
To be filled out by a physician

Name: _______________________________ Date: __________________

Medical Diagnosis: ________________________________

Physical Prognosis: ________________________________

Reasons for possible functional assessment:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

☐ Paratransit Evaluation

Contradictions to evaluation (if any)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

________________________________________

Physician signature*

*Western Reserve Hospital, Easy Street entrance requires this prescription to be completed by a: MD, DO, DC, or DPN
In Case of Emergency:

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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Primary Phone</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

I verify that all statements are true and correct to the best of my knowledge. I understand that supplying false information can disqualify my application and/or subsequent registration. I authorize METRO RTA to obtain verification of any information given in this application and to obtain essential medical information necessary for determination of paratransit eligibility. I also agree to submit myself for an in-person evaluation by METRO RTA and/or its acting agency for determination of paratransit eligibility.

___________________________________________________
Applicant’s signature

If completed by someone other than the applicant:

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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Primary Phone</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Signature</th>
<th>Date</th>
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**DISCLAIMER**

This certification form will be used to determine your eligibility for METRO ADA Paratransit Services. Paratransit Services is an origin-to-destination public transportation service for persons with disabilities who are prevented from using METRO’s fixed-route transportation bus services. METRO buses are fully accessible to individuals with disabilities. You must complete the entire form. Answer every question. Incomplete forms will be returned. A physician must verify your disability, prognosis, and date of occurrence(s). Verification can be obtained directly from your physician or from an agency that has record of the physician statement on file. This information must be submitted with the application and on the enclosed form. The information you provide is confidential. It will only be shared with persons involved with METRO’s eligibility determination process and other transit providers to facilitate travel in those areas, and will not be provided to any other person or agency.