



City of Rochester, MN  
Transit & Parking  
4300 East River Road NE  
Rochester, 55906  
507-328-2450  
[www.rptride.com](http://www.rptride.com)

## APPLICATION FOR ZIPS PARATRANSIT SERVICES

### Eligibility for ZIPS is a transportation decision, not a medical one

Determinations are based on a person's functional ability to use Fixed Route buses. Eligibility is **not** solely based on disability, age or medical diagnosis.

ZIPS Dial-a-Ride service is available for individuals with disabilities who are unable to ride Rochester Public Transit Fixed Route\* buses. This is a shared-ride, door-to-door, Operator-assisted service\*\* which requires advance reservations. Customers must complete the application process before using this service. Accessible formats are available upon request.

**If you have questions about ZIPS eligibility or if you need help with the application form, Rochester Public Transit staff is available to assist you. Please call 507.328.7433.**

Please complete the application form in full. **Incomplete applications will be returned**, which may delay the eligibility determination process.

**ZIPS certification is valid for 3 years. You will need to reapply after the expiration date.**

WHEN AND HOW WILL YOU FIND OUT IF YOU ARE ELIGIBLE?

**Once the application has been reviewed, applicants will be notified of the eligibility decision in writing and by phone.** Eligibility determinations are made **within 21 days** of the date we receive your application. If a decision is not made within 21 days, we will provide you with ZIPS services until a determination is made.

If you are approved for ZIPS, you will be given a ZIPS Service Guide with information about the service. If it is determined that Fixed Route buses are a feasible option for some or all of your trips, you will be notified in writing of the reasoning for this decision and information will be provided about how to appeal the determination.

**Return completed applications to:**

**Zumbro Independent Transit Service**  
4300 East River Road NE  
Rochester, MN 55906

**Fax:** 507.328.2432  
**Phone:** 507.328.7433  
**Email:** [rpt@rochestermn.gov](mailto:rpt@rochestermn.gov)

\*Large transit buses operated on designated routes by RPT.

\*\*Operators assist passengers through the first door of a building at both their point of origin and their destination. First door is defined as giving inside access to the building

# PART A: Applicant Information

New Application or  Renewal

First name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Preferred Pronouns: \_\_\_\_\_

Street address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of birth \_\_\_\_\_

Primary phone number (required) \_\_\_\_\_

Would you like to sign up for the **RPT Mobile Fare Smartphone App**?

Yes (If yes) please provide email: \_\_\_\_\_

No

What is your preferred language? \_\_\_\_\_

Are you currently using Fixed Route Transportation Services?  Yes  No

If yes, please share why this service no longer meets your needs:

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If not, please share why this service doesn't meet your needs:

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Are you currently driving?  Yes  No

If yes, please share why driving no longer meets your needs:

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Do you currently have a PCA that helps you with daily care?  Yes  No

If yes, please explain what tasks / cares they help you with

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<b>FOR INTERNAL OFFICE USE ONLY</b>
RECEIVED ON: _____
APPROVED ON: _____
EXPIRES ON: _____
APPROVED BY: _____
Date Denied: _____
Date letter was sent: _____

## PART B: Eligibility Information

What type or types of disabilities prevent you from using Fixed Route buses? Check all that apply.

- Physical disability     Visual impairment/blindness     Developmental disability     Mental illness  
 Other     None

Please explain how your disability prevents you from being able to use fixed route transportation:

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Is the disability above permanent or temporary?

- Permanent     Temporary, expected it to last for another \_\_\_\_\_ month's

Indicate any mobility aids or equipment you use. Check all that apply.

- Cane     Manual wheelchair     Service animal     White cane     Powered wheelchair     Crutches  
 Communication device     Walker     Powered scooter or cart     Portable oxygen     Alphabet board  
 I do not use a mobility aid or equipment     Other (please describe) \_\_\_\_\_

For wheelchairs or scooters, is it - More than 30 inches wide?     Yes     No

More than 48 inches long?     Yes     No

For Ramp Capacity:

For powered devices, is the combined weight over 800 pounds?     Yes     No

For manual wheelchairs, is the combined weight over 350 pounds?     Yes     No

\*\*\*If the combined weight exceeds 800 lbs. (for powered devices) or 350 lbs. (for manual wheelchairs), a Personal Care Assistant will be required to assist the rider on and off the bus.\*\*\*

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## PART B: Eligibility Information

### SIGNATURE INFORMATION

Please complete Box A *unless* the individual is a minor or has a legal guardian. In that case, the parent or legal guardian should complete Box B.

A. I understand the purpose of this application is to determine Dial-a-Ride eligibility. I certify that the information provided in this application is true and correct. I understand falsification of information could result in a loss of Dial-a-Ride privileges as well as penalties under the law. I agree to notify ZIPS if I no longer need to use Dial-a-Ride services.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

B. I understand the purpose of this application is to determine Dial-a-Ride eligibility of the Applicant. I certify that the information provided in this application is true and correct. I understand falsification of information could result in a loss of Dial-a-Ride privileges as well as penalties under the law. I agree to notify ZIPS if the Applicant no longer needs to use Dial-a-Ride services.

I consent to the Applicant's interview and any possible assessment of travel abilities and limitations to determine Dial-a-Ride eligibility.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

If assisting in the completion this application, please provide the following information.

Name (please print)\_\_\_\_\_

Relationship to applicant\_\_\_\_\_

Address\_\_\_\_\_

Agency\_\_\_\_\_Phone \_\_\_\_\_

## Assessing Abilities to Use Fixed Route Transit Services

**Please have this section completed by a care professional** (Physician, Physician's Assistant, Advanced Practice Registered Nurse, Chiropractor, Physical Therapist, Case Manager, Personal Care Attendant, etc.)

What is the nature of the applicant's disability? (Check all that apply).

- The applicant has a **physical disability** that prevents them from traveling to and from the bus or boarding and disembarking from the vehicle.
- The applicant has a **cognitive disability** which prevents them from using regular Rochester Public Transit buses.
- The applicant has a **sensory disability** which prevents them from using regular Rochester Public Transit buses.
- The applicant has a **mental health disability** that prevents them from using the regular Rochester Public Transit service.

### Is the applicant's disability:

- Permanent       Temporary, I expect it to last for another \_\_\_\_\_ month's

If temporary, please explain the length of time service will be needed or the circumstances under which the applicant needs service.

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Title \_\_\_\_\_ Printed Name \_\_\_\_\_

Clinic/Agency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ - \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_ @ \_\_\_\_\_

I certify by my signature that \_\_\_\_\_ (**applicant's name**), in my professional opinion, meets the criteria as I have indicated above.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_