Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

Helping people. It's who we are and what we do.

Dena Schmidt
Administrator

Dear Applicant:

Thank you for your interest in the Taxi Assistance Program **(*Subsidized Transportation Program)*.** The Taxi Assistance Program (TAP) helps meet the transportation needs of older adults and people with disabilities, who have limited resources and few, if any, transportation options. The program provides discounted taxicab coupon booklets to qualified individuals. To qualify for the TAP program applicant must:

- Be a Nevada Resident
- Be at least 60 years of age **OR** demonstrate permanent disability, applicants must be verified with a letter from their doctor **OR** Social Security award letter.
- Have a monthly income below 300% of the Federal Poverty Guidelines.

Qualifying applicants must provide the following required documents:

- A copy of their Valid Nevada Photo ID/Driver's License.
- A completed Taxi Assistance Program Registration Form.
- Proof of Income:
    - A copy of three (3) months of most RECENT and COMPLETE Bank Statement *(showing ALL deposit transactions)* **AND** A copy of Current Social Security Award Letter **OR** Department of Welfare SNAP Award letter.

      OR
    - A copy of your previous year's Federal Tax Return or IRS Tax Transcript

Please note, failure to provide verifications/documents may result in a delay or ineligibility of TAP application. If you have questions, please contact the Taxi Assistance Program at (702) 486-3581.

Sincerely,

Taxi Assistance Program Staff

Return by Mail to:

Aging and Disability Services Division
Attn: Taxi Assistance Program
7150 Pollock Drive
Las Vegas, NV 89119

☐ New Application ☐ Reassessment Application Last Purchase Date _____

Please Print **TAP REGISTRATION FORM** **Please Print**

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____ / ____ / ____ PHONE NUMBER: (___) _____

CURRENT ADDRESS: _____ MAILING ADDRESS: (If Different) _____

APT/UNIT/SPC#

CITY/ZIP _____ _____

EMERGENCY CONTACT INFORMATION *(Not Spouse or Partner):*

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (___) _____ WORK OR CELL PHONE: (___) _____

☐ **Visually Impaired** ☐ **Legally Blind** ☐ **Hearing Impaired**

ETHNICITY

☐ HISPANIC OR LATINO

☐ NON-HISPANIC OR LATINO

RACE

- ☐ WHITE, CAUCASIAN
- ☐ AMERICAN INDIAN / ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK / AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE and WHITE
- ☐ ASIAN AND WHITE
- ☐ BLACK OR AFRICAN AMERICAN AND WHITE
- ☐ NATIVE INDIAN/ALASKAN NATIVE AND BLACK/AFRICAN
- ☐ AMERICAN
- ☐ NORTH AFRICAN
- ☐ MIDDLE EASTERN
- ☐ OTHER:_____

Preferred language of applicant:

English☐ Spanish☐ Other: _____

My anticipated Primary Use of Coupons is:

☐ Leisure Activities ☐ Medical: Doctor Visit, Rx

☐ Essential Shopping ☐ Banking

☐ Senior Service Network: Senior Center, Assisted Living

☐ Religious Activities ☐ Work / Volunteer

☐ Health/ Fitness

Marital Status

☐ Married ☐ Divorced ☐ Single ☐ Widowed

MONTHLY INCOME: _____

Number of People Supported by Income: _____

How did you hear about the Taxi Assistance Program? _____

For TAP Staff Only

Date Reviewed:

Monthly Income:

Household Size:

Determined Status ☐**Eligible** ☐**Not Eligible**

Reason not Eligible:

- ☐ Not a Permanent Residence of Nevada
- ☐ Not Age 60 or Older
- ☐ Not a Person with Permanent Disability
- ☐ No Supporting Documentation
- ☐ Not within Defined Income Limit
- ☐ Other

TIER CATEGORY

1. ☐ **2.** ☐ **3.** ☐ **4.** ☐ **5.** ☐

I declare and affirm under penalty of perjury that the statements made herein are true and correct to the best of my knowledge, information and belief.

I understand that:

- **Taxi coupons are non-transferrable; penalties may include program removal.**
- **Taxi Coupons must be redeemed by the expiration date.**

_____ _____

Client Signature Date

Aging and Disability Services Division Sexual Orientation and Gender Identity and Expression (SOGI) Addendum

This information is used to comply with the requirements set forth by NRS 239B.022 - 239B.026. Only the Department of Health and Human Services will have access to this information. Your responses will be kept private and secure. *(If the form is anonymous, please indicate that).* The information will not be used for a discriminatory purpose. Providing this information is voluntary.

1. What sex were you assigned at birth, such as on your original birth certificate? (Mark One Answer)
   - ○ a. Male
   - ○ b. Female
   - ○ c. Prefer not to disclose

2. How do you describe yourself? (Mark One Answer)
   - ○ a. Male
   - ○ b. Female
   - ○ c. Transgender Man/Trans Male
   - ○ d. Transgender Woman/Trans Female
   - ○ e. Genderqueer/gender non-conforming
   - ○ f. Different Identity; Please Specify: _____
   - ○ g. Prefer not to disclose

3. Which of the following best represents your sexual orientation identity? (Mark one Answer)
   - ○ a. Straight or Heterosexual
   - ○ b. Gay
   - ○ c. Lesbian
   - ○ d. Bisexual
   - ○ e. Not listed: Please specify _____
   - ○ f. Prefer not to disclose