Aging and Disability Services Division **Senior & Disability Rx** **3416 Goni Road D-132** **Carson City NV 89706**	**DO YOU NEED HELP PAYING FOR YOUR PRESCRIPTION MEDICATION WHEN YOU GO INTO THE GAP?** **NEVADA'S SENIOR AND DISABILITY Rx PROGRAM MAY BE THE SOLUTION!**	**NEVADA** **SENIOR &DISABILITY Rx** **Providing prescription assistance for qualifying seniors and individuals with disabilities** **For more information:** **1-866-303-6323 Option 7** **Fax: 775-687-0576** **http://adsd.nv.gov**

NEVADA WILL PROVIDE ASSISTANCE WITH THE COST OF PRESCRIPTION MEDICATION WHEN YOU ARE IN THE GAP IF:

A. Eligible for Medicare: Applicants who are eligible for Medicare Part D must enroll in a Medicare prescription plan and use that program as the first source of help with prescriptions. In addition, Part C beneficiaries who qualify for extra federal help with Part D costs (such as premiums, deductibles and co-payments) must apply for and, if approved, use that help. This is important because the federal help may cover more of the beneficiary's out-of-pocket costs than the Senior & Disability Rx program. Beneficiaries with very low incomes and limited assets should contact the Social Security Administration at 1-800-772-1213 to find out more.

B. Age/Disability: Applicant and spouse (if spouse is also applying) must be age 18 through 61 with verifiable disability, or at least 62 years of age at time of application.

C. Income: Includes income from all sources for both applicant and spouse. For current income limits, call 1-866-303-6323 Option 7 OR go to: http://adsd.nv.gov.

D. Residency: Applicants must have lived continuously in Nevada for at least 12 consecutive months (one year) prior to the date of application.

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

A. Please include a copy of your 2016 tax return or your last 12-months bank statements for income verification (all copies are non-returnable).
B. Please include a copy of your Medicare card and Medicare Part D card.
C. Married couples need to submit only one application for both participants.
D. You will be notified of eligibility status within 30-45 days of receipt of your application unless the Aging and Disability Services Division needs to request additional information to process your application.

The benefits to you if you are Medicare eligible:

- Help with prescription costs if you are subject to the Part D coverage gap ("donut hole").
- Help with monthly premiums to participating Medicare Prescription Plan.

FOR STATISTICSAL PURPOSES

Put an A in one box for applicant and an S in one box for spouse (this information is voluntary and confidential):

☐ ☐ American Indian/Alaskan Native ☐ ☐ Hispanic/Latino ☐ ☐ African American

☐ ☐ White/Caucasian ☐ ☐ Asian/Pacific Islander

MAIL COMPLETED APPLICATION TO:

Aging and Disability Services Division (ADSD)
Senior and Disability Rx
3416 Goni Road D-132
Carson City NV 89706

Or

Fax 775-687-0576

Please PRINT to complete all sections below.				
Last Name	**First Name**	**Middle Initial**	**DOB**	**SSN**
Residence Address		**City, State, Zip Code**		**Phone Number**
				☐ Male ☐ Female
Mailing Address		**City, State, Zip Code**		**Gender**
Medicare # with Letter		**Effective Date**	**Part D Plan Name (include copy of card)**	

Even if not applying, must include Spouse information				
Last Name	**First Name**	**Middle Initial**	**DOB**	**SSN**
Medicare # with Letter		**Effective Date**	**Part D Plan Name (include copy of card)**	

Have you and your Spouse (if applicable) **lived in Nevada 12 consecutive months at the date of this application?**

☐ YES ☐ NO

If you are in the Coverage Gap: Contact your Part-D Provider for the exact date and complete below:

Gap Date:		**Pharmacy Name:**	
Pharmacy Phone #:		**Pharmacy Fax #:**	

LIST ALL CURRENT MONTHLY INCOME RECEIVED

Type of Income (source)	Applicant Amount	+ Spouse Amount	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
TOTAL GROSS MONTHLY INCOME: (Include Social Security, SSI, Pensions/IRAs, Interest & Dividends, Wages, Real Estate Rental, VA compensation & other income/resources. Exclude A&B Premiums)			$

Capital Gains (loss) on last tax return	$	**Business Income (loss) on last tax return**	$

By signing this application, I agree to the following:

- To immediately provide to the Aging and Disability Services Division (ADSD) written notice of a change of address, name, household income, marital status, telephone number, status of disability, and Medicaid, SSI, or Medicare eligibility.
- If it is determined that I received Senior or Disability Rx benefits that I was not eligible to receive, I will refund all amount paid on my behalf—to be sent to ADSD.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize ADSD to verify my eligibility, including my income, and I will provide documentation of my disability upon request.

This authorization is valid for a period of 14 months from the date of my signing the application.

I DECLARE THAT THE INFORMATION IN THIS APPLICATION FOR THE SENIOR AND DISABILITY PRESCRIPTION PROGRAM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND ABILITY (by signing below you make this declaration)

Applicant Signature:		**Date:**	
Spouse Signature:		**Date:**	

Confidentiality Statement: Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for purposes connected to the administration of this program. Unauthorized disclosures are a violation of the Health Insurance Portability and Accountability Act (HIPAA) and may result in civil penalties. **NOTE**: If someone other than the applicant or spouse signs, a copy (non-returnable) of a Power-of-Attorney or Letter of Guardianship must be attached.