Incomplete applications will not be processed and will be sent back to the applicant.

NEVADA'S SENIOR & DISABILITY Rx PROGRAM

Providing prescription assistance for qualifying seniors and individuals with disabilities that are subject to the Part D coverage gap ("donut hole")

Previous application versions will not be accepted after December 31, 2017.

APPLICANT'S INFORMATION

Gender: ☐ Male ☐ Female

Race/Ethnicity (optional): ☐ American Indian/ Alaskan Native ☐ White/ Caucasian ☐ Asian/ Pacific Islander ☐ Hispanic Ethnicity ☐ African American ☐ Other

Current Marital Status: ☐ Married* ☐ Single ☐ Divorced ☐ Widowed

Last Name: _____

First Name: _____ Middle Initial: ____

Birth Date: ____ / ____ / ____ Soc. Sec. No. ____ - ____ - ____

Medicare No. (with letter): _____ Effective Date: ____ / ____ / ____ (for Part A)

Part D Plan Name: _____

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

Entered Gap, Date: ____ / ____ / ____ Pharmacy Name: _____

Pharmacy Telephone: ____ - ____ - ____ Pharmacy Fax: ____ - ____ - ____

Why are you applying to the program? ☐ Currently or will be in the coverage gap (donut hole) ☐ Need a special enrollment period ☐ Other

Please explain why, if other reason: _____

SPOUSE'S INFORMATION (Required if married, even if spouse is not applying)

* Married couples need to submit only one application for both participants

Gender: ☐ Male ☐ Female

Race/Ethnicity (optional): ☐ American Indian/ Alaskan Native ☐ White/ Caucasian ☐ Asian/ Pacific Islander ☐ Hispanic Ethnicity ☐ African American ☐ Other

Last Name: _____

First Name: _____ Middle Initial: ____

Birth Date: ____ / ____ / ____ Soc. Sec. No. ____ - ____ - ____

Medicare No. (with letter): _____ Effective Date: ____ / ____ / ____ (for Part A)

Part D Plan Name: _____

ADDRESS INFORMATION

Residential Address: _____ Unit: _____

City: _____ State: ____ Zip Code: _____

Mailing ☐ Same as above

Address: _____ Unit: _____

City: _____ State: ____ Zip Code: _____

Telephone: ____ - ____ - ____ Have you and your spouse lived in Nevada for 12 consecutive months? ☐ Yes ☐ No

LIST ALL CURRENT INCOME (Income Verification Required)

INCOME LIMITS ARE FROM ALL SOURCES FOR BOTH APPLICANT AND SPOUSE. CALL NUMBER BELOW FOR INCOME LIMITS

OTHER INCOME includes the following: Alimony, Child Support, Contributions/Gifts, Educational Assistance/Student Loans, Foster Care, Gambling Winnings, General Assistance, Inheritance, Insurance Settlements, Life Insurance, Loans, Military Allotment, Mining Claims, Property Rentals, Room Income, Self-Employment Income, Strike Benefits, Subsidized Housing, Supplemental Security Income (SSI), Supported Living Arrangement (SLA), TANF Assistance, Temporary Disability, Trust Income, Unemployment Insurance, Utility Allowance/Rebate Check, Veteran's Benefits or Worker's Compensation (this list is not all-inclusive).

ROUND PREVIOUS 12 MONTHS INCOME TO THE NEAREST DOLLAR -- DO NOT INCLUDE CENTS

	APPLICANT	SPOUSE
Net Social Security	$ ___,___	$ ___,___
Gross Wages	$ ___,___	$ ___,___
Interest, Dividends and Capital Gains	$ ___,___	$ ___,___
Retirement Income	$ ___,___	$ ___,___
Other Income	$ ___,___	$ ___,___
Grand Total	$ ___,___	$ ___,___

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.

SRX/DRX PROGRAM WILL PROVIDE ASSISTANCE WITH THE COST OF PRESCRIPTION MEDICATION WHILE IN THE COVERAGE GAP

A. Eligible for Medicare: Applicants 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 2 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.

SIGNATURE (Required)

I DECLARE THAT THE INFORMATION IN THIS APPLICATION FROM THE SRx/DRx PROGRAM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND ABILITY (by signing below you make this declaration)

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

Signature of: ☐ Applicant ☐ POA- Power of Attorney (Attach to application if applicable)

APPLICANT OR POA SIGNATURE:	DATE:	SPOUSE SIGNATURE:	DATE:

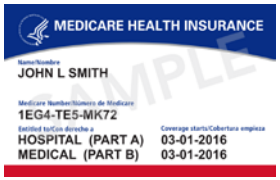
Confidentiality Statement: Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for purposed connected to the administration of this program. Unauthorized disclosures are a violation of the Health Insurance Portability and Accountability Act (HIPAA) and may result in civil penalties.

SUBMITAL PROCEDURE

Send the following to: ADSD SRx/DRx 1860 E. Sahara Ave, Las Vegas, NV 89140 or fax: 702-486-3236 or email: nvrx@adsd.nv.gov

☐ Signed Application

☐ A **copy** Medicare Health Insurance Card



☐ A **copy** Medicare Part D Card

☐ Income Verification (Current Tax Return OR Last 12 months bank statements)

☐ POA (if applicable)

OFFICE USE ONLY

You will be notified of eligibility status within 30-45 days of receipt of your application unless the additional information is needed for processing.

For more information, please call 1-866-303-6323 select option 2 or fax: 775-687-0576 or email us: nvrx@adsd.nv.gov or check out our website: adsd.nv.gov.