

Requirements

- A. Age/Disability:** Applicant and spouse (if spouse is also applying) must be age 18 through 61 with verifiable disability, or 62 years of age at time of application.
- B. Income:** Includes income from all sources for both applicant and spouse. For current income limits, call 1-866-303-6323 or go to: <http://aging.state.nv.us/>
- C. Residency:** Applicants must have lived continuously in Nevada for at least one year (12 consecutive months) prior to the date of application.
- D. Eligibility for Medicare:** Applicants who are eligible for Medicare Part D must enroll in a Medicare prescription drug plan and use that program as the first source of help with prescriptions. In addition, Part D 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 Senior Rx or Disability Rx can. Beneficiaries with very low incomes and limited assets should contact the Social Security Administration at 1-800-772-1213 to find out more.
- Important information about your application**
- A.** You do not need to attach income, age, or disability verification to this application. However, you may be asked to provide such documentation at a later date.
- B.** Please include a copy of Medicare card and Medicare Part D card if Medicare eligible.
- C.** Married couples need to submit only one application for both spouses.
- D.** You will be notified of eligibility status within 30-45 days of receipt of your application unless the Department of Health and Human Services needs to request additional information to process your application.
- E.** Fax: 775-687-0576
- F.** Sign this application on the back and mail to: **Aging and Disability Services Division Senior Rx and Disability Rx 3416 Goni Road, Bldg. D, Suite 132 Carson City, NV 89706**

PLACE
STAMP
HERE

Aging and Disability Services Division
Senior Rx and Disability Rx
3416 Goni Road, Bldg. D, Suite 132
Carson City, NV 89706



AGING AND DISABILITY SERVICES DIVISION
SENIOR RX AND DISABILITY RX
3416 GONI RD BLDG D STE 132
CARSON CITY NV 89706



NEVADA'S Senior Rx and Disability Rx

*Providing prescription assistance
for qualifying seniors and
individuals with disabilities*

<http://aging.state.nv.us/>

Do you need help paying
for your prescription
medications?

NEVADA'S

Senior Rx and

Disability Rx

may be the solution!

Apply Now!



NEVADA'S Senior Rx and Disability Rx

The State of Nevada will provide assistance with the cost of prescription medicines if you qualify:

- Age 62 or older
- Age 18 through 61 with disability
- Nevada resident continuously for at least the last 12 months
- For current income limits, call 1-866-303-6323 or go to: <http://aging.state.nv.us/>

The Benefits to You:

- Not Medicare Eligible:**
- No monthly premium
 - No deductible
 - Co-payments of \$2.50 or \$10
 - Coverage limit of \$5,100

Medicare Eligible:

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

If you think you qualify, complete the attached application and drop in any mail box with first-class postage.

For more information:

1-866-303-6323

<http://aging.state.nv.us/>

Complete this form, sign below, and return it to the address listed on the back.

Applicant Information <small>(Please Print)</small>	Applicant Contact Information																
<p>Last Name, First Name, Middle Initial _____</p> <p>Date of Birth _____ Social Security Number _____</p> <p>IF MEDICARE ELIGIBLE (REQUIRED INFORMATION)</p> <p>Medicare Number with LETTER _____ Medicare Effective Date _____</p> <p>Medicare Prescription Drug Plan Name (please include a copy of your card) _____</p> <p>Monthly Part D Premium (if any) _____ Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you interested in the SRX dental program? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>What is your disability? _____ <small>(no abbreviations, please)</small></p> <p>If you receive any help based on your disability, provide the agency name. _____</p>	<p>Residence Address _____ <small>Number, Street, Apt. or Space Number</small></p> <p>City, State, ZIP Code _____</p> <p>Mailing Address _____ <small>Number, Street, Apt., Space Number or P.O. Box</small></p> <p>City, State, Zip Code _____</p> <p>Telephone (_____) _____</p> <p>E-Mail Address _____</p>																
Spouse Information <small>(Please Print)</small>																	
<p>Are you applying for Senior or Disability Rx also? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Even if not applying, please provide the following information.</p> <p>Last Name, First Name, Middle Initial _____</p> <p>Date of Birth _____ Social Security Number _____</p> <p>IF MEDICARE ELIGIBLE (REQUIRED INFORMATION)</p> <p>Medicare Number with LETTER _____ Medicare Effective Date _____</p> <p>Medicare Prescription Drug Plan Name (please include a copy of your card) _____</p> <p>Monthly Part D Premium (if any) _____ Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you interested in the SRX dental program? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>What is your disability? _____ <small>(no abbreviations, please)</small></p> <p>If you receive any help based on your disability, provide the agency name. _____</p>																	
List All Current Monthly Income Received																	
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Type of Income</th> <th style="width: 15%;">Applicant</th> <th style="width: 15%;">Spouse</th> <th style="width: 15%;">Total</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> <td style="text-align: right;">_____</td> </tr> </tbody> </table> <p>Total Gross monthly income from all sources _____ <small>(Income includes Social Security-excluding premiums for A&B only, SSI, Pensions/IRAs, Interest and Dividends, Wages, Real Estate Rental, VA compensation, and others.)</small></p> <p>Capital Gains (Loss) on last tax return _____</p> <p>Business Income (Loss) on last tax return _____</p>		Type of Income	Applicant	Spouse	Total	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Type of Income	Applicant	Spouse	Total														
_____	_____	_____	_____														
_____	_____	_____	_____														
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Confidentiality Statement																	
<p>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.</p>																	

Applicant Name (Last) _____ (First) _____

For Statistical Purposes Only

- Check one box for applicant and one box for spouse (if any)
- | | |
|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> African American |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> White | |
- This information is voluntary and will be kept separate and confidential.

By signing this application, I agree to the following:

- To immediately provide to the Department of Health and Human Services 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 Rx or Disability Rx benefits that I was not eligible to receive, I will refund to the Department of Health and Human Services all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Health and Human Services 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 signature below.

I declare that the information in this application for the Senior Rx or Disability Rx program is accurate to the best of my knowledge and ability.

Applicant Signature _____ Date _____

Print Name _____ Date _____

Spouse Signature _____ Date _____

Print Name _____ Date _____

Please Note: If someone other than the applicant or spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.