Dear Applicant:

Thank you for your interest in the Taxi Assistance Program (Subsidized Transportation Program). The Taxi Assistance Program (TAP) is intended to help meet the needs of older adults and persons having permanent disabilities with limited resources and transportation options. The program provides discounted taxicab coupon booklets to qualified applicants.

To qualify for the TAP program applicant must:

- Be a Nevada Resident
- Be at least 60 years of age OR Have a Permanent Disability that can be verified with a letter from the applicant’s physician or the applicants Social Security award letter.
- Have a monthly income below 300% of the Federal Poverty Guidelines.

Qualifying applicants must provide the following for program registration:

- A copy of their Nevada Photo ID/Driver’s License.
- A completed Taxi Assistance Program Registration Form.
- Proof of Income:
  - A copy of your 2018 Federal Tax Return or IRS Tax Transcript OR
  - A copy of three (3) months of the most RECENT Bank Statements that show ALL deposits made as proof of total income AND A copy of Current Social Security Award Letter OR Department of Welfare SNAP Award letter.

If you have questions, please contact the Taxi Assistance Program at (702) 486-3581.

Sincerely,

Shaina Robinson, Program Coordinator
Taxi Assistance Program

Return by Mail or In Person to:
Aging and Disability Services Division
Attn: Taxi Assistance Program.
1860 E. Sahara Avenue
Las Vegas, NV 89104

Nevada Department of Health and Human Services
Helping People -- It's Who We Are And What We Do
Please Print                      TAP REGISTRATION FORM                     Please Print

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

DATE OF BIRTH: ______ / ______ / ______  PHONE NUMBER: ( ______ )

CURRENT ADDRESS: _____________________________________________

MAILING ADDRESS: _____________________________________________

APT/UNIT/SPC# __________________________  CITY/ZIP ______

(If Different)

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  ☐ OTHER __________________________

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

TI ER CATEGORY

1. ☐  2. ☐  3. ☐  4. ☐  5. ☐

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

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 __________________________

Taxi Assistance Program Registration Form: Revised 04/2019