

STEVE SISOLAK
Governor



RICHARD WHITLEY, MS
Director

DENA SCHMIDT
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES DIVISION

Regional Office
1860 East Sahara Avenue
Las Vegas, NV 89104
Telephone (702) 486-3545 • Fax (702) 486-3569
<http://adsd.nv.gov>

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,

A handwritten signature in black ink, appearing to read "Shaina Robinson".

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

Please Print

TAP REGISTRATION FORM

Please Print

NAME (First/Last): _____

MALE

FEMALE

DATE OF BIRTH: _____ / _____ / _____

PHONE NUMBER: (____) _____

CURRENT

ADDRESS: _____

MAILING _____

APT/UNIT/SPC#

ADDRESS: _____

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

MONTHLY INCOME: _____

Number of People Supported by Income: _____

RACE

WHITE, CAUCASIAN

AMERICAN INDIAN / ALASKAN NATIVE

ASIAN

BLACK / AFRICAN AMERICAN

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

OTHER _____

How did you hear about the Taxi Assistance

Program? _____

If you do not speak English, what is your primary language? _____

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

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 _____