NEVADA'S SENIOR & DISABILITY PRESCRIPTION PROGRAM

Providing a monthly subsidy for Medicare Part D or Advantage Plan Part D premiums for qualifying seniors and individuals with disabilities

Send completed application and required documents to one of the following:

Mail to: **ADSD** **Attn: SRx/DRx** **1860 E. Sahara Ave.** **Las Vegas, NV 89104**	**Or fax to: 775-687-0576** **Or email to: nvrx@adsd.nv.gov**
Previous application versions will not be accepted after May 1, 2020.	

Application for SRx/DRx Program

Information About You (The Applicant)	
Who is applying for the SRx/DRx program? ☐ Just You ☐ You and your spouse	
Name of Applicant (first name, middle initial, last name)	**Telephone Number** (include area code)
Date of Birth (month, day, year)	**Social Security Number**
Marital Status ☐ Single ☐ Married ☐ Legally Separated	**Gender** ☐ Male ☐ Female
Physical Address	**City, State, Zip code**
Mailing Address	**City, State, Zip code**
Email Address	**Other Telephone Number**
Have you been a resident of Nevada for at least 12 months? ☐ Yes ☐ No	**Requesting Authorized Representative form?** ☐ Yes ☐ No
Ethnicity ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other	
Information About Your Spouse (If married and living together, you must complete this section and send income documents for you **and** your spouse, even if your spouse is not applying for benefits.)	
Name of Spouse (first name, middle initial, last name)	**Spouse Social Security Number**
Spouse Date of Birth (month, day, year)	**Spouse Gender** ☐ Male ☐ Female

Other Program Assistance		
Other Program Assistance Questions	**You (Applicant)**	**Your Spouse**
Has an application been submitted for **Medicare Extra Help** (Low Income Subsidy) through Social Security Administration?	☐ Yes ☐ No	☐ Yes ☐ No
If you checked **Yes** that you have applied for **Medicare Extra Help**, what was your determination and percent of LIS? **(Attach Determination Letter from Social Security Administration)**	☐ Approved ☐ Denied Percent LIS ψψψ%	☐ Approved ☐ Denied Percent LIS ψψψ%
Has an application been submitted for **Medicaid** through the Division of Welfare and Supportive Services (DWSS)?	☐ Yes ☐ No	☐ Yes ☐ No
If you checked **Yes** that you have applied for **Medicaid**, what was your determination? **(Attach Determination Letter from Medicaid)**	☐ Approved ☐ Denied	☐ Approved ☐ Denied

Medicare Health Insurance (Please complete this section using information from your Medicare card)		
Medicare Health Insurance Information	**You (Applicant)**	**Your Spouse**
Name as it appears on Medicare Card		
Medicare MBI Number		
Part A Effective Date		
Part B Effective Date		

Part D Plan or Advantage Plan Information (Please complete this section using information from your Prescription Plan Card)		
Part D or Advantage Plan Information	**You (Applicant)**	**Your Spouse**
Part D or Advantage Plan Name		
Are you requesting a (SEP) Special Enrollment Period to enroll or change your Part D or Advantage Plan?	☐ Yes ☐ No	☐ Yes ☐ No

Required information and documentation:

- If a copy of your current tax return is submitted with your application, you do not need to fill out the income information below and you do not need to submit any additional income documentation.
- If current tax return is not submitted, list all current income below. Enter the amount you receive each month. Income verification documents are required to be submitted with your application. Required documents are listed below. For income sources with an asterisk (*) below, required documentation is either a benefit award letter or tax document.

Type of Income (Per Month)	You (Applicant)	Your Spouse (if applicable)
Social Security Income (*)	**$**	**$**
Veterans' Pensions and Compensation (*)	**$**	**$**
Unemployment Insurance Benefit (*)	**$**	**$**
Disability or Workers' Compensation Insurance (*)	**$**	**$**
Railroad Retirement Benefits (*)	**$**	**$**
Pension; untaxed portion (*)	**$**	**$**
Service Allowance; dependence of servicemen or servicewomen (*)	**$**	**$**
Annuities; retirement account (Tax Document)	**$**	**$**
Employment Compensation (Tax Document)	**$**	**$**
Gambling; capital gains (Tax Document)	**$**	**$**
Rental; property earnings (Tax Document)	**$**	**$**
Alimony/Child Support; court-ordered provisions (Court Issued Document)	**$**	**$**
Support Payments/Public Welfare Payments (Award Letter)	**$**	**$**
Gifts Over $300; inheritance (Bank Statement)	**$**	**$**
Self-Employment Compensation (Tax Document)	**$**	**$**
Other income not listed above: Tax-free interest; Payments for lost time; Life insurance proceeds in excess of $5,000, and inheritances (Corresponding Documents)	**$**	**$**
For Internal Use only		

By signing this application, I agree to the following:

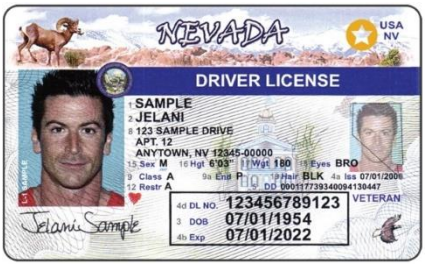
- To provide to the Aging and Disability Services Division (ADSD) within 20-days, written notice of a change of address, name, household income, marital status, telephone number and Medicaid, LIS, or Medicare eligibility.
- If it is determined that I received Senior or Disability Rx benefits that I was not eligible to receive, I will refund all amounts 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.
- This signature authorization is valid for a period of 12-months from the date of my signing the 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.

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

Have You Included the Following?

☐ **Income verification** If current tax return is submitted, no additional documents are required.	☐ **POA**- Power of Attorney (if applicable)	☐ **Determination letters** for Medicare Extra Help and/or Medicaid (if applicable)
☐ A copy of **Nevada driver's license or identification** 	☐ A copy of **Medicare Health Insurance card** 	☐ A copy of **Medicare Part D** card 

You will be notified of eligibility status within 45 days of receipt of your application and all other required information, unless additional information is needed for processing.

PROGRAM IS SUBJECT TO FUNDING AVAILABILITY

For more information, please call **1-866-303-6323 select option 2**
Or contact us by fax: **775-687-0576** or email: **NVRX@ADSD.nv.gov** or visit our website: **ADSD.nv.gov**