

Joe Lombardo
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION
Helping people. It's who we are and what we do.



Dena Schmidt
Administrator

Dear Applicant:

Thank you for your interest in the Taxi Assistance Program (***Subsidized Transportation Program***). The Taxi Assistance Program (TAP) helps meet the transportation needs of older adults and people with disabilities, who have limited resources and few, if any, transportation options. The program provides discounted taxicab coupon booklets to qualified individuals. To qualify for the TAP program applicant must:

- Be a Nevada Resident
- Be at least 60 years of age **OR** demonstrate permanent disability, applicants must be verified with a letter from their doctor **OR** Social Security award letter.
- Have a monthly income below 300% of the Federal Poverty Guidelines.

Qualifying applicants must provide the following required documents:

- A copy of their Valid Nevada Photo ID/Driver's License.
 - A completed Taxi Assistance Program Registration Form.
 - Proof of Income:
 - A copy of three (3) months of most RECENT and COMPLETE Bank Statement (showing ALL deposit transactions) **AND** A copy of Current Social Security Award Letter **OR** Department of Welfare SNAP Award letter.
- OR**
- A copy of your 2022 Federal Tax Return or IRS Tax Transcript

Please note, failure to provide verifications/documents may result in a delay or ineligibility of TAP application. If you have questions, please contact the Taxi Assistance Program at (702) 486-3581.

Sincerely,

Taxi Assistance Program Staff

Return by Mail to:

**Aging and Disability Services Division
Attn: Taxi Assistance Program
7150 Pollock Drive
Las Vegas, NV 89119**

Regional Office

7150 Pollock Drive • Las Vegas, Nevada 89119
702-486-3545 • Fax 702-792-0143 • adsd.nv.gov

New Application

Reassessment Application

Last Purchase Date _____

Please Print

TAP REGISTRATION FORM

Please Print

NAME (First/Last): _____

MALE FEMALE

DATE OF BIRTH: ____ / ____ / ____

PHONE NUMBER: (____) _____

CURRENT ADDRESS: _____
APT/UNIT/SPC# _____
CITY/ZIP _____

MAILING ADDRESS: _____
(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
- AMERICAN INDIAN OR ALASKAN NATIVE and WHITE
- ASIAN AND WHITE
- BLACK OR AFRICAN AMERICAN AND WHITE
- NATIVE INDIAN/ALASKAN NATIVE AND BLACK/AFRICAN
- AMERICAN
- NORTH AFRICAN
- MIDDLE EASTERN
- OTHER: _____

MONTHLY INCOME: _____

Number of People Supported by Income: _____

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 _____

Joe Lombardo
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION
Helping people. It's who we are and what we do.



Dena Schmidt
Administrator

Aging and Disability Services Division Sexual Orientation and Gender Identity and Expression (SOGI) Addendum

This information is used to comply with the requirements set forth by NRS 239B.022 - 239B.026. Only the Department of Health and Human Services will have access to this information. Your responses will be kept private and secure. *(If the form is anonymous, please indicate that)*. The information will not be used for a discriminatory purpose. Providing this information is voluntary.

1. What sex were you assigned at birth, such as on your original birth certificate? (Mark One Answer)
 - a. Male
 - b. Female
 - c. Prefer not to disclose

2. How do you describe yourself? (Mark One Answer)
 - a. Male
 - b. Female
 - c. Transgender Man/Trans Male
 - d. Transgender Woman/Trans Female
 - e. Genderqueer/gender non-conforming
 - f. Different Identity; Please Specify: _____
 - g. Prefer not to disclose

3. Which of the following best represents your sexual orientation identity? (Mark one Answer)
 - a. Straight or Heterosexual
 - b. Gay
 - c. Lesbian
 - d. Bisexual
 - e. Not listed: Please specify _____
 - f. Prefer not to disclose