

DEPARTMENT OF HUMAN SERVICES

Rique Robb Administrator

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

Dear Applicant:

Thank you for your interest in the Taxi Assistance Program (TAP) that provides discounted taxicab fares to qualified individuals, age 60 and older, and persons of any age with a permanent disability through coupon booklets that are accepted by all taxicab companies in Clark County.

Program Qualifications:

Be a Nevada resident
 Provide a copy of the applicant's Nevada Photo ID/Driver's License.
Be at least 60 years of age, OR
Have a permanent disability
 Provide a letter from the applicant's physician or their Social Security Award letter.
Submit a completed Taxi Assistance Program Registration form; see page 2.
Monthly income below 300% of the Federal Poverty Guidelines. Applicants must provide income from
all sources for both applicant and/or spouse, if applicable.
 A copy of your previous year's Federal Tax Return or IRS Tax Transcript
OR

- A copy of the most recent bank statement, including blank pages, as proof of total income showing all deposit transactions AND
- o A copy of Current Social Security Award Letter OR Department of Welfare SNAP Award letter.

Return by Mail to:

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

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

Thank you,

Taxi Assistance Program Team

Please Print TAP REGISTRATION FORM Please Prin NAME (First/Last):	New Application	Reassessme	nt Application	Last Purchase Date
DATE OF BIRTH:				Please Prin
CURRENT ADDRESS: ADDRESS: (IF Different) EMERGENCY CONTACT INFORMATION (Not Spouse or Partner): NAME (First/Last):	NAME (First/Last):			☐ MALE ☐ FEMALE
ADDRESS: CITY/ZIP EMERGENCY CONTACT INFORMATION (Not Spouse or Partner): NAME (First/Last):		/	PHONE NUMBER:	()
ADDRESS: (IT Different) EMERGENCY CONTACT INFORMATION (Not Spouse or Partner): NAME (First/Last):			MAILING	
EMERGENCY CONTACT INFORMATION (Not Spouse or Partner): NAME (First/Last):	APT/UNIT/SPC#			
NAME (First/Last):	CITY/ZIP		(If Different)	
HOME PHONE: WORK OR CELL PHONE:	EMERGENCY CONTACT INFOR	MATION (Not Spou	se or Partner):	
ETHNICITY HISPANIC OR LATINO Number of People Supported by Income: Number of People Supported by Income:	NAME (First/Last):		RELAT	TIONSHIP:
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Client Signature

Date



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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