

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 (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**
 - 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

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: _____

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

☐ 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: _____

How did you hear about the Taxi Assistance

Program? _____

Preferred language of applicant:

English ☐ Spanish ☐ Other: _____

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 _____

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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