NEVADA'S **DisabilityRx**

The State of Nevada will provide assistance with the cost of prescription medicines if you qualify:

- Age 18 through 61 with disability
- Nevada resident continuously for at least the last 12 months
- For current income limits, call **1-866-303-6323** or go to: **http://dhhs.nv.gov/DisabilityRx.htm**

The Benefits to You:

Not Medicare Eligible:

- No monthly premium
- No deductible
- Co-payments of $10 or $25
- Coverage limit of $5,100

Medicare Eligible:

- Help with monthly premiums to Medicare Prescription Drug Plan
- Help with prescription costs if you are subject to the Part D coverage gap (or "donut hole").

If you think you qualify, complete the attached application and drop in any mail box. No postage necessary.

For more information:

1-866-303-6323

http://dhhs.nv.gov/DisabilityRx.htm

Tear along this perforation. Fold up completed application form, moisten glue strip and apply to edge indicated.

Complete this form, sign below, and return it to the address listed on the back.

Applicant Name *(Last)*_____ *(First)*_____

Applicant Contact Information

Residence Address *Number, Street, Apt. or Space Number*

City, State, Zip Code

Mailing Address *Number, Street, Apt., Space Number or P.O. Box*

City, State, Zip Code

Telephone (___)_____

E-Mail Address_____

Spouse Information *(Please Print)*

Are you applying for Disability Rx also? Yes☐ No☐
Even if not applying, please provide the following information.

***Last Name**, First Name, Middle Initial*

Date of Birth

Social Security Number

*IF MEDICARE ELIGIBLE (**REQUIRED** INFORMATION IF APPLYING)*

Medicare Number with LETTER

Medicare Effective Date

Medicare Prescription Drug Plan Name (no abbreviations please)

Monthly Part D Premium (if any)

Male☐ Female☐

Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes☐ No☐

If applying, what is your disability? (no abbreviations please)_____

If you receive any help based on your disability, provide the agency name._____

Applicant Information *(Please Print)*

***Last Name**, First Name, Middle Initial*

Date of Birth

Social Security Number

*IF MEDICARE ELIGIBLE (**REQUIRED** INFORMATION)*

Medicare Number with LETTER

Medicare Effective Date

Medicare Prescription Drug Plan Name (no abbreviations please)

Monthly Part D Premium (if any)

Male☐ Female☐

Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes☐ No☐

What is your disability? (no abbreviations please)_____

If you receive any help based on your disability, provide the agency name._____

List All Current Monthly Income Received

Type of Income	Applicant		Spouse		Total
		+		=	$0.00
		+		=	$0.00
		+		=	$0.00
		+		=	$0.00

Total monthly income from all sources . . . . . .
(Income includes Social Security, SSI, Pensions/IRAs, Interest and Dividends, Wages, Real Estate Rental, and Others.)

Capital Gains (Loss) on last tax return_____

Business Income (Loss) on last tax return_____

Confidentiality Statement

Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for purposes connected to the administration of this program. Unauthorized disclosures are a violation of the Health Insurance Portability and Accountability Act (HIPAA) and may result in civil penalties.

For Statistical Purposes Only

Check one box for applicant and one box for spouse (if any)

☐☐ American Indian/Alaskan Native
☐☐ Hispanic
☐☐ White
☐☐ African American
☐☐ Asian/Pacific Islander

This information is voluntary and will be kept separate and confidential.

By signing this application, I agree to the following:

- To immediately provide to the Department of Health and Human Services written notice of a change of address, name, household income, marital status, telephone number, status of disability, and Medicaid, SSI or Medicare eligibility.
- If it is determined that I received Disability Rx benefits that I was not eligible to receive, I will refund to the Department of Health and Human Services all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Health and Human Services to verify my eligibility, including my income, and I will provide documentation of my disability upon request. This authorization is valid for a period of 14 months from the date of my signature below.

I declare that the information in this application for the Disability Rx program is accurate to the best of my knowledge and ability.

_____
Applicant Signature

_____
Print Name *Date*

_____
Spouse Signature

_____
Print Name *Date*

Please Note: *If someone other than the applicant or spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.*

Requirements

A. **Age/Disability:** Applicant and spouse (if spouse is also applying) must be age 18 through 61 with a verifiable disability.

B. **Income:** Includes income from all sources for both applicant and spouse. For current income limits, call 1-866-303-6323 or go to: http://dhhs.nv.gov/DisabilityRx.htm

C. **Residency:** Applicants must have lived continuously in Nevada for at least one year (12 consecutive months) prior to the date of application.

D. **Eligibility for Medicare:** Applicants who are eligible for Medicare Part D must enroll in a Medicare prescription drug plan and use that program as the first source of help with prescriptions. In addition, Part D beneficiaries who qualify for extra federal help with Part D costs (such as premiums, deductibles and co-payments) must apply for and, if approved, use that help. This is important because the federal help may cover more of the beneficiary's out-of-pocket costs than Disablity Rx can. Beneficiaries with very low incomes and limited assets should contact the Social Security Administration at 1-800-772-1213 to find out more.

Important information about your application

A. You do not need to attach income, age or disability verification to this application. However, you may be asked to provide such documentation at a later date.

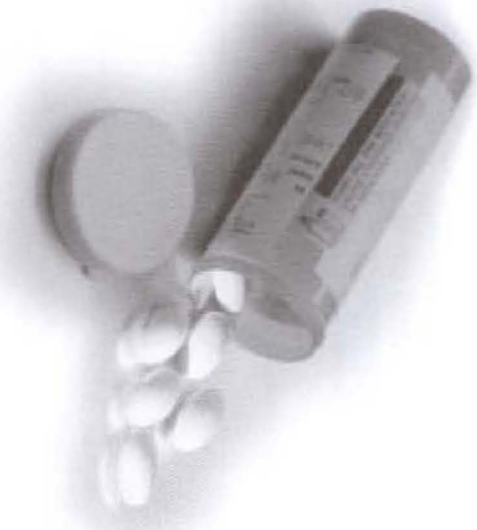
B. Married couples need to submit only one application for both spouses.

C. You will be notified of eligibility status within 30–45 days of receipt of your application unless the Department of Health and Human Services needs to request additional information to process your application.

D. Sign this application on the back and mail to:

State of Nevada
Disability Rx
P.O. Box 21230
Carson City, Nevada 89721-9909

Attach glue edge to this edge.



NEVADA'S **Disability Rx**

Providing prescription assistance for qualifying individuals with disabilities

http://dhhs.nv.gov/DisabilityRx.htm

Do you have a disability?

Do you need help paying for your prescription medications?

NEVADA'S **Disability Rx**

may be the solution!

Apply Now!