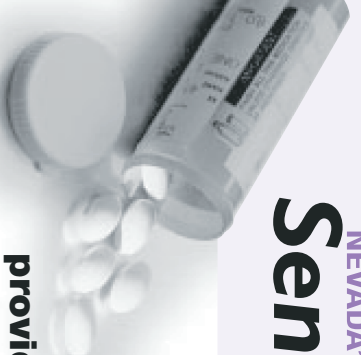


NEVADA'S Senior Rx



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

- Age 62 or older
- 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/SeniorRx.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/SeniorRx.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 Information <small>(Please Print)</small> | Applicant Contact Information | | | | | | | | | | | | | | | | | | | | |
|--|---|-----------|--------|-------|-------|---|-------|---|-------|---|-------|---|-------|---|-------|---|-------|---|-------|---|--|
| <p>Last Name, First Name, Middle Initial _____</p> <p>Date of Birth _____ Social Security Number _____</p> <p>IF MEDICARE ELIGIBLE (REQUIRED INFORMATION)</p> <p>Medicare Number with LETTER _____ Medicare Effective Date _____</p> <p>Medicare Prescription Drug Plan Name (no abbreviations please) _____</p> <p>Monthly Part D Premium (if any) _____ Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Residence Address _____ <small>Number, Street, Apt. or Space Number</small></p> <p>_____ <small>City, State, Zip Code</small></p> <p>Mailing Address _____ <small>Number, Street, Apt., Space Number or P.O. Box</small></p> <p>_____ <small>City, State, Zip Code</small></p> <p>Telephone (____) _____</p> <p>E-mail Address _____</p> | | | | | | | | | | | | | | | | | | | | |
| Spouse Information <small>(Please Print)</small> | | | | | | | | | | | | | | | | | | | | | |
| <p>Are you applying for Senior Rx also? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Even if not applying, please provide the following information.</p> | | | | | | | | | | | | | | | | | | | | | |
| <p>List All Current Monthly Income Received</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Type of Income</th> <th style="width: 15%;">Applicant</th> <th style="width: 15%;">Spouse</th> <th style="width: 10%;">Total</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td style="text-align: center;">+</td> <td>_____</td> <td style="text-align: center;">=</td> </tr> <tr> <td>_____</td> <td style="text-align: center;">+</td> <td>_____</td> <td style="text-align: center;">=</td> </tr> <tr> <td>_____</td> <td style="text-align: center;">+</td> <td>_____</td> <td style="text-align: center;">=</td> </tr> <tr> <td>_____</td> <td style="text-align: center;">+</td> <td>_____</td> <td style="text-align: center;">=</td> </tr> </tbody> </table> <p>Total monthly income from all sources _____ <small>(Income includes Social Security, SSI, Pensions/IRAs, Interest and Dividends, Wages, Real Estate Rental, and Others.)</small></p> <p>Capital Gains (Loss) on last tax return _____</p> <p>Business Income (Loss) on last tax return _____</p> | Type of Income | Applicant | Spouse | Total | _____ | + | _____ | = | _____ | + | _____ | = | _____ | + | _____ | = | _____ | + | _____ | = | <p>Last Name, First Name, Middle Initial _____</p> <p>Date of Birth _____ Social Security Number _____</p> <p>IF MEDICARE ELIGIBLE (REQUIRED INFORMATION IF APPLYING)</p> <p>Medicare Number with LETTER _____ Medicare Effective Date _____</p> <p>Medicare Prescription Drug Plan Name (no abbreviations please) _____</p> <p>Monthly Part D Premium (if any) _____ Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/></p> |
| Type of Income | Applicant | Spouse | Total | | | | | | | | | | | | | | | | | | |
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| Confidentiality Statement | | | | | | | | | | | | | | | | | | | | | |
| <p>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.</p> | | | | | | | | | | | | | | | | | | | | | |

Applicant Name (Last) _____ (First) _____

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, and Medicaid, SSI or Medicare eligibility.
- If it is determined that I received Senior 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. 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 Senior 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:** Applicant and spouse (if spouse is also applying) must be 62 years of age at the date of application.
- 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/SeniorRx.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 Senior 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.

Attach glue edge to this edge

Important information about your application

- A. You do not need to attach income or age 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
Senior Rx
P.O. Box 21230
Carson City, Nevada 89721-9909

<http://dhhs.nv.gov/SeniorRx.htm>

NEVADA'S
SeniorRx
Providing prescription assistance
for qualifying seniors

Seniors...

Do you need help paying for your prescription medications?

NEVADA'S
SeniorRx
may be the solution!

Apply Now!

