GOOD SAMARITAN CLINIC of PASCO, Inc.
5334 Aspen Street, New Port Richey, FL 34652
(727) 848-7789

Application for Medical Services

☐ New Patient ☐ Requalifying Patient

PLEASE READ THIS APPLICATION VERY CAREFULLY:
Welcome to the Good Samaritan Health Clinic. Before you can be seen as a patient at the Good Samaritan Health Clinic you will be required to complete this application for services and provide the following: documentation indicated in this application.

1. Proof of Pasco County Residency such as a Florida Driver's License or utility bill showing a Pasco County address with your name.

2. Proof of US Citizenship or legal permanent residency such as a birth certificate, social security card, passport, voter ID, or green card.

PLEASE PRINT

Patient Name: _____Phone: _____
Address: _____City:_____ZIP:_____
Age: _____ DOB: _____ SEX: _____ SSN: _____ Marital Status_____
IN CASE OF EMERGENCY CONTACT: _____ Phone: _____
DO YOU HAVE INSURANCE? ____ Yes _____ No If yes, ___ Medicaid ___ Medicare ___ Other_____
ARE THERE ANY DISABILITIES THAT YOU WOULD LIKE US TO BE MADE AWARE OF? _____
REFERRED BY: _____ WHAT IS YOUR MEDICAL PROBLEM? _____
_____

LIST ALL CONTRIBUTORS IN HOUSEHOLD TO INCOME:

Name of person receiving income	Source of income (name of employer, Social Security, Pension, TANF, Food Stamps, etc.)	Monthly income

TOTAL NUMBER OF ADULTS IN HOUSEHOLD: _____ CHILDREN: _____ TOTAL INCOME: _____
Are there any special circumstances you wish us to know about? _____
_____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE .

Signature: _____ Date: _____

2019

Patient Attestation/Authorization

I hereby certify that all information provided by me on this application and financial disclosure is true and accurate. I certify that the "household" income is at 200% or below the Federal Poverty level. (i.e. Family size 1= $2,082. per month, see below) I do not have any type of health insurance. I certify that I live in Pasco County. All patients must be US citizens or legal permanent residents.

I hereby authorize the Good Samaritan Health Clinic of Pasco, Inc. to obtain or verify any information necessary regarding my physical and/or financial status in order to determine my eligibility for assistance. I give my consent to release my information to pharmaceutical companies for auditing purposes in the bulk replacement patient assistance programs.

I hereby grant permission to and authorize the Good Samaritan Health Clinic of Pasco, Inc. to release any and all health related information in my medical records to other parties in order for a referral to take place for further medical treatment. I understand my financial information will not be a part of my medical record and will be contained in a separate confidential file.

NOTICE: I certify I will contact the clinic in the event I have an insurance and/or income changes (increased or decreased) for my household – i.e. you receive Medicaid/Medicare, disability, SSI, Workers Compensation, etc., loss of employment, if you become involved in a legal action resulting in an increase or decrease of income, receive inheritance of finances or property or proceeds from selling property, you will disclose this to the clinic.

Signature_____

Print Name_____

Witness signature_____ Date_____

Family Size	**1**	**$2,082 per month**	**Family Size**	**4**	**$4,292 per month**
Family Size	**2**	**$2,818 per month**	**Family Size**	**5**	**$5,028 per month**
Family Size	**3**	**$3,555 per month**	**Family Size**	**6**	**$5,765 per month**

***each additional person add $737**

White	Single	Employment	Less than $10,000
Hispanic	Couples/ No Dep	Full Time	10,000 - 20,000
African American	Single Parent	Part Time	20,000 – 30,000
Asian	2 Parent Family	Unemployed seeking work	30,000 – 40,000
American Indian	Other Arrangements	Unemployed unable to work	40,000 – 50,000
Other	18-55	55+	Disabled 50,000+