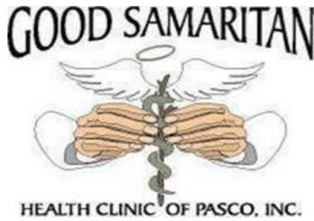

GOOD SAMARITAN CLINIC of PASCO, Inc.
5334 Aspen Street, New Port Richey, FL 34652
(727) 848-7789

Application for Medical Services — 2021

☐ 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.
3. Proof of income for your entire household.
4. DO NOT MAIL, E-MAIL OR FAX THIS APPLICATION OR ANY DOCUMENTATION. YOU MUST PRESENT IN PERSON AND HAVE AN INTERVIEW WITH AN ELIGIBILITY AND REFERRAL SPECIALIST.

PLEASE PRINT CLEARLY

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(s) 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: _________________________

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2021

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= $2,147 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 obtain a job, receive Medicaid/Medicare, SSD, 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: ____ Date: __________________

Witness Signature:____ Date: __________________

Circle the option that applies:

Family Size	Household Monthly income (gross)	Family Size	Household Monthly income (gross)
1	$2,147	5	$5,173
2	$2,903	6	$5,930
3	$3,660	7	$6,687
4	$4,417	8	$7,443

APPLICATION CONTINUES: PLEASE COMPLETE THE FOLLOWING 2 PAGES

GOOD SAMARITAN CLINIC of PASCO,Inc.
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DEMOGRAPHICS

Because of our grant reporting requirements, completion of the demographics section helps us better serve you.

Please choose one option from each column

AGE RANGE	HOUSEHOLD	EMPLOYMENT	INCOME RANGE
18-30	Single	Full Time	Less than $10,000
31-54	Couples/ No Dep	Part Time	10,000 – 20,000
55+	Single Parent	Unemployed/seeking work	20,000-30,000
	2-Parent Family	Unemployed/unable to work	30,000-40,000
	Other Arrangements	Self Employed	40,000-50,000
			Disabled 50,000+

RACE		ETHNICITY		LANGUAGE
African American	Japanese	Central American	Not Hispanic or Latino	English
Alaskan Native	Middle East	Cuban	Puerto Rican	Spanish
American Indian	Native Hawaiian or Pacific Islander	Dominican	South American	
Arabic		Hispanic or Latino/Spanish	Spaniard	Other (specify):
Asian	White	Latin American/ Latin/Latino		
Egyptian	Other (specify):	Mexican		
European				
Jamaican				

PLEASE CHECK ONE:

___ I can read, write and understand English and, therefore, can participate in my healthcare without the aid of an interpreter.

___ An interpreter aided in completing this application.

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What is your living situation?	Homeowner	Renter	Other (specify)
Do you own an automobile?	Yes	No	
Did you file federal income tax with the IRS last year?	Yes	No	If no, fill out 4506-T
Do you have any of the following assets:			
Certificate of Deposits?	Yes	No	If yes, amount:
Stocks/Bonds?	Yes	No	If yes, value:
Other assets?	Yes	No	If yes, explain:
Are you a veteran of the U.S. Armed Forces?	Yes	No	
Are you a Pasco County "year-round" resident?	Yes	No	
Do you have health insurance of any type?	Yes	No	If yes, specify:
Do you have Medicaid/Medically Needy or Share of Cost?	Yes	No	If yes, provide letter for documentation
Do you receive SSI or SSD?	Yes	No	If yes, provide letter from Social Security with monthly benefit.
Have you applied for Social Security Disability?	Yes	No	Date filed:
Do you have a Worker's Compensation case pending?	Yes	No	If yes, please provide details/ medical condition below
Do you have a previous or continuing accident or personal injury lawsuit pending?	Yes	No	If yes, please provide reason and medical condition below

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FOR OFFICE USE ONLY

__Approved for one year

__Approved until: __________________

__Denied:_________________________

SPECIAL NOTES: