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

Application for Medical Services 2024

☐ 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:

1. A copy of your **valid** Florida driver's license or state issued photo I.D.
2. Proof of US citizenship or legal permanent residency such as a birth certificate, social security card, U.S. passport, voter ID, or green card
3. Proof of income for your entire household
4. Other documents that may be required for specific situations
5. 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:_____

EMERGENCY CONTACT (relationship): _____Phone: _____

DO YOU HAVE INSURANCE? _____ Yes _____ No If yes, _____ Medicare _____ Medicaid _____Other

HAVE YOU OR **WILL** YOU BE APPLYING FOR DISABILITY? _____ No _____ Have Applied _____ Will Apply

REFERRED BY: _____WHAT IS YOUR MEDICAL PROBLEM? _____

_____

LIST ALL CONTRIBUTORS TO HOUSEHOLD INCOME:

Name of person(s) receiving income	Relationship to Patient	Source of income (Employer, Social Security, Pension, TANF, Food Stamps)	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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Patient Attestation/ Authorization

By my signature below, I hereby certify:

1. That all information provided by me on this application and financial disclosure is true and accurate
2. That the "household" income is at 200% or below the Federal Poverty level (see chart below)
3. That I do not have health insurance
4. That I live in Pasco County and am a US citizen or legal permanent resident

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, should I require medications from 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 insurance and/or income changes in my household - i.e. I obtain or lose a job, receive Medicaid/Medicare, SSD, SSI, Workers Compensation, etc. I further certify I will inform the clinic if I 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. I 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	$2,510	6	$6,993
2	$3,407	7	$7,890
3	$4,303	8	$8,787
4	$5,200	9	$9,683
5	$6,097	10	$10,580
		EACH ADDITIONAL	$ 897

APPLICATION CONTINUES: PLEASE COMPLETE THE FOLLOWING 2 PAGES

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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
18-21	Single	Full Time	Less than $10,000
22-30	Couples with dependents	Part Time	$10,000-$20,000
31-40	Couple without dependents	Unemployed/seeking work	$20,000-$30,000
41-55	2-Parent Family	Unemployed/unable to work	$30,000-$40,000
56-64	Single Parents	Self Employed	$40,000-$50,000
	Other arrangements	Disabled and working	$50,000+
		Disabled and not working	

RACE			ETHNICITY			NATIVE LANGUAGE
African American	Japanese		Central American	Not Hispanic or Latino		English
Alaskan Native	Middle Eastern		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; therefore, I can participate in my healthcare without the aid of an interpreter.

___ An interpreter aided in completing this application; therefore, I will provide my own interpreter for services at Good Samaritan. I understand that Good Samaritan cannot provide interpreter services.

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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 taxes?	Yes	No	
Do you have any of the following assets:			
Certificates of Deposit?	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	If yes, are you eligible for VA medical benefits?
Are you a year-round Pasco County resident?	Yes	No	
Do you have health insurance of any type?	Yes	No	If yes, specify:
Do you have Medicaid Share of Cost?	Yes	No	If yes, provide letter for documentation
Do you receive SSI or SSD?	Yes	No	If yes, provide the most recent Social Security benefit statement.
Have you applied for Social Security Disability?	Yes	No	If yes, date filed:
Do you have a Worker's Compensation case pending?	Yes	No	If yes, please provide details/ medical condition below
Do you have an accident or personal injury lawsuit pending?	Yes	No	If yes, please provide reason and medical condition below.

FOR OFFICE USE ONLY

NOTES:

Approved _____Yes _____ No

_____Requalification Date