

WELCOME TO THE GOOD SAMARITAN HEALTH CLINIC

5334 Aspen Street, New Port Richey, FL 34652
(727) 848-7789 Fax (727) 848-7890

Dear Applicant:

Attached you will find an application for services at the Good Samaritan Health Clinic. At this time, we want to make you aware of the following factors:

Due to many situations, it should be understood by patients being seen at the Good Samaritan Health Clinic, that certain medications cannot be ordered and given to patients.

The following drug categories will not be initiated (prescribed) by the Good Samaritan Health Clinic physician or renewed even if it is a drug chronically necessary from a non- Good Samaritan Health Clinic physician.

**TRANQUILIZERS
ANTIDEPRESSANTS
NARCOTIC OR NARCOTIC-LIKE ANALGESICS
APPETITE SUPPRESSANTS
DRUGS TO CONTROL ANXIETY
DRUGS TO TREAT PSYCHOLOGICAL DISORDERS, BEHAVIOR DISORDERS, OR
MENTAL ILLNESSES
DRUGS TO HELP SLEEP DISORDERS (HYPNOTIC OR SLEEPING MEDICATIONS)**

THE FOLLOWING SERVICES ARE NOT PROVIDED:

1. Emergency treatment, fractures, 2nd opinions or annual checkups.
2. Birth control, pregnancy tests, or prenatal care.
3. Tests or treatment for AIDS, sexually transmitted diseases, TB or Hepatitis A or B testing.
4. Disability evaluations for social security, workers compensation, litigation, employment or pre-employment or physicals and school or sports physicals.
5. Immunizations, flu, pneumonia or allergy shots.

Please be advised that some specialty care such as: NEUROLOGY, ORTHOPEDIC OR ENT ARE LIMITED OR NOT AVAILABLE AT ALL.

We request a \$5.00 donation for each visit to the clinic.

I have read and understood the above statements.

Signature of Patient

Date

Signature of Witness

Date



Good Samaritan Health Clinic of Pasco, Inc.

5334 Aspen Street, New Port Richey, FL 34652

(727) 848-7789

Application for Medical Services

New Patient

Requalifying Patient

Patient Name: _____	Phone: _____
	(Home) (Work)
Address: _____	City: _____ Zip: _____
Date of Birth: _____	Age: _____ Social Security #: _____

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 required household financial information and other documentation indicated in this application.

If you do not provide all requested documents, a determination cannot be made regarding your application and eligibility for medical services. Financial disclosure regarding income and assets for **ALL** members of your "household" must be provided. **A "household" is defined as one or more individuals (related or unrelated) living at one residence as one economic unit.**

You must be ineligible for Medicaid in order to apply for medical services at the Good Samaritan Health Clinic. Patient eligibility for medical care is re-evaluated annually, so you must re-apply every year.

BRING THE FOLLOWING DOCUMENTS TO YOUR QUALIFYING INTERVIEW

(Refusal to provide all documents listed automatically disqualifies you for services.)

1. Florida Drivers License – Pasco County address **OR** Florida identification with Pasco County address and voter's registration.
2. Social Security card
3. Proof of Income: All employers pay statements/proofs of income for **EACH** member of the household for the last 3 pay periods (weekly, bi-weekly or monthly). **OR** FEDERAL IRS TAX RETURN: Submitted last year for **each member of the household**. (Note: During January through April 15th of each year, we will accept W-2's prior to filing IRS Tax Return. Copy of Tax Return must be provided after filing.)
4. Additional Income: Documents relating to other household income, including pensions, SSI, SSD, Food Stamps, etc. **for each member of the household must be presented.**

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Social Security card must be presented

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Phone lines are open as follows:

Monday: 10:00 AM – 4:00 PM

Tuesday, Wednesday & Thursday: 10:00 AM – 6:00 PM

We are closed from 12:00 – 1:00 everyday for lunch.

THE CLINIC IS CLOSED ON FRIDAYS.

YOU MUST HAVE ALL REQUESTED DOCUMENTS LISTED ABOVE TO DETERMINE YOUR ELIGIBILITY FOR THE GOOD SAMARITAN HEALTH CLINIC SERVICES. IF YOU DO NOT BRING ALL DOCUMENTS WITH YOU, YOUR APPLICATION FOR MEDICAL SERVICES WILL BE DELAYED.

PLEASE COMPLETE ALL QUESTIONS BELOW

1. Total monthly income: _____
2. Circle one: Homeowner Renter Other: _____
3. Do you own an automobile? Yes No Year/Model: _____
4. Did you file Federal Income Tax with the IRS last year? Yes No
5. I have 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: \$ _____)
6. Are you a veteran of the U.S. Armed Forces? Yes No
7. Are you a Pasco County "year-round" resident? Yes No
8. Do you have health insurance? Yes No
9. Does your spouse have health insurance? Yes No
10. Are you offered insurance through your employer? Yes No
11. Do you have Medicaid/Medically needy? Yes No Share of cost? Yes No
12. Do you receive SSI or SSD? Yes No
(If yes, provide letter from Social Security with monthly benefit.)
13. Have you applied for Social Security Disability? Yes No
(If yes, date filed: _____)
14. Do you have a Worker's Compensation case pending? Yes No
If yes, please provide details/medical conditions: _____

15. Do you have a previous or continuing accident or personal injury lawsuit pending? Yes No
If yes, reason and medical condition: _____

Patient Authorization / Attestation

I hereby certify that all information provided by me on this application and financial disclosure is true and accurate. I understand that if any information or statements are proven to be untrue or inaccurate, **I will be held responsible for any and all medical expenses incurred, and I will be denied future services at the Good Samaritan Health Clinic.**

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 further authorize the Good Samaritan Health Clinic to conduct a credit search if it is deemed necessary.

I hereby grant permission to/and authorize the Good Samaritan Health Clinic of Pasco, Inc. to release any and all information, including information of a psychological, psychiatric, alcohol or drug-related nature, HIV/AIDS, STD, Hepatitis test results, and laboratory and radiology reports to other parties in order to provide me further medical treatment and/or testing if said services are conducted as a result of a referral made by the Good Samaritan Health Clinic.

I understand that financial information will not be part of my medical record and will be contained in a separate confidential file.

NOTICE: If your income changes (increased or decreased) ie: you receive disability, SSI, Worker’s 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 must report this to the clinic immediately. THIS APPLIES TO ALL MEMBERS OF THE HOUSEHOLD.**

Signature: _____

Print Name: _____
(First Name) (Middle Initial) (Last Name)

Date: _____

Witness: _____ Date: _____

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PLEASE PRINT

NAME: _____ PHONE: _____
ADDRESS: _____ CITY: _____ ZIP: _____
AGE: _____ D.O.B: _____ SEX: _____ SSN: _____ MARITAL STATUS: _____
IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____
EMERGENCY CONTACT RELATIONSHIP: _____
DO YOU HAVE INSURANCE? YES NO If yes, please specify: Medicaid Medicare Other
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, Medicaid, Food Stamps, etc.)	Net monthly income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

I HEREBY CERTIFY THESE FACTS TO BE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE COUNSELOR

Interviewer: _____ Date: _____

Counselors/Reception staff: When client brings in needed paperwork from list above, please add your initials and date next to document received.