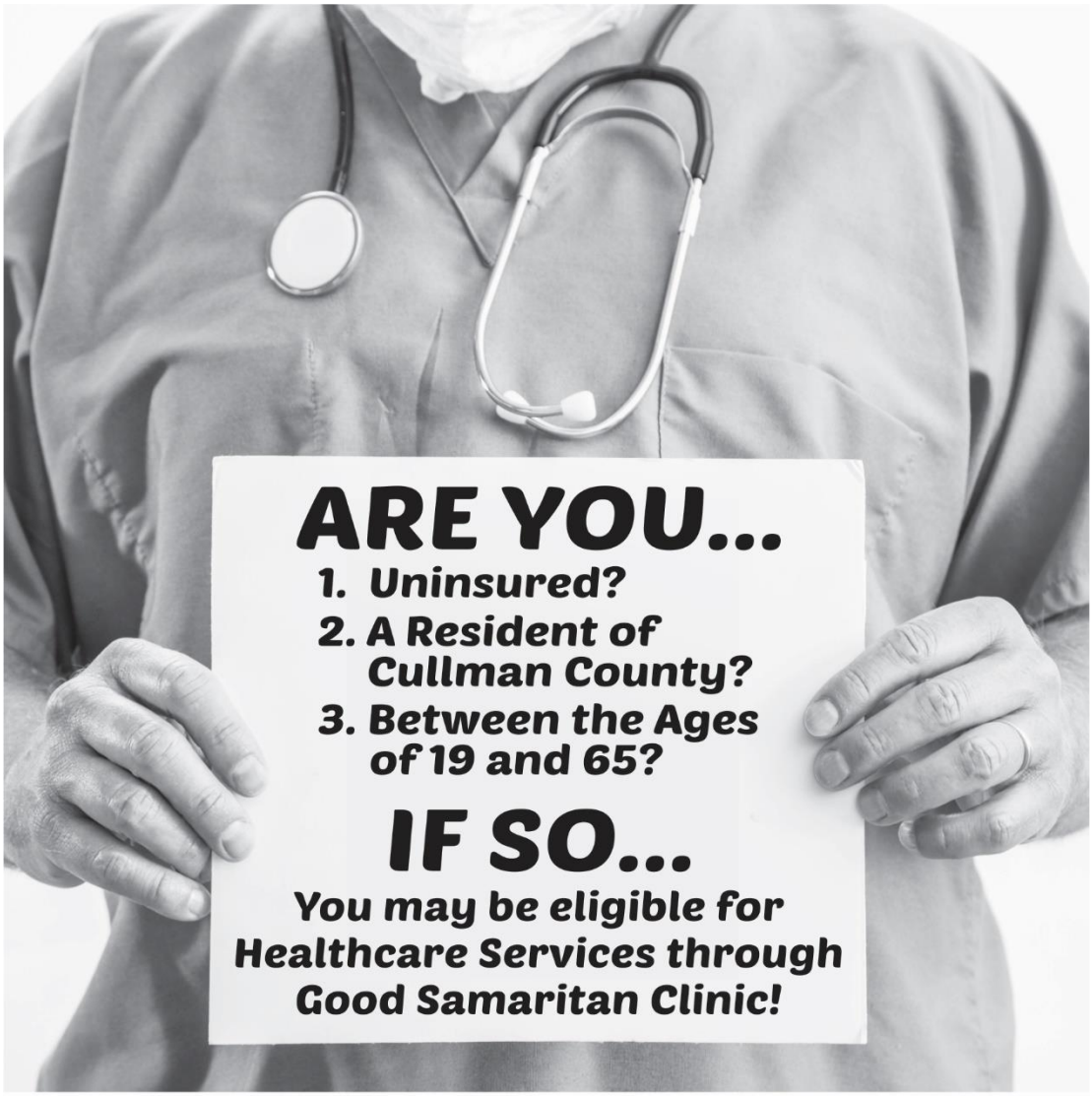

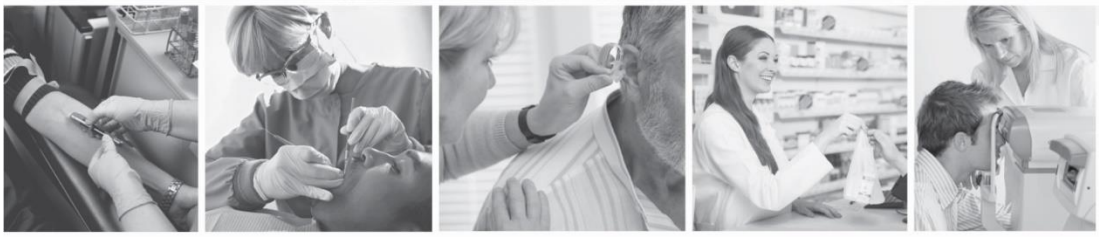

GOODSAMARITAN HEALTHCLINIC

www.goodsamaritancullman.com

United Way
United Way of Cullman County

@goodsamaritancullman
@samaritancullman

401 Arnold Street NE, Suite A
Cullman, AL 35055

256-775-1389

If you need help completing this application, please call 256-255-5963.

We will be happy to schedule a time for someone to assist you.

Good Samaritan Health Clinic

401 Arnold St. NE, Cullman, AL 35055
Phone: 256-775-1389

Office Hours: Monday – Thursday 800 a.m. - 4:00 p.m. (Closed Daily for Lunch 12p.m. – 1p.m.) and Friday 8:00 a.m. - 12:00 p.m.

Documentation that applies to you in this checklist are required. NO exceptions will be made.

You must live in Cullman County, be at least 19 years old and do not have Medical Insurance including: Medicare, Medicaid, VA medical benefits or private/other health insurance coverage.

Identification

____ Alabama Driver's License (with correct name and address)
____ Social Security Card (with correct name)

Proof of ALL Household Income

____ **Federal Income Tax Return** for the previous year or **4506-T** (If you do not file taxes the Clinic will provide this form)
(Provide Social Security Cards for *EVERYONE* listed on the Tax Return) W-2's will **NOT** be accepted.

____ 5 Current and Consecutive Paystubs (30 days prior to enrollment date for employed applicants)

____ SNAP (Food Stamps) or WIC Award Letter of monthly allotment verification

____ Social Security/SSI Original Award letter (Only for applicant, if receiving benefits)

____ Proof of Social Security/Disability Income (No bank statements will be accepted)

____ Alimony, child support, pension, Veteran benefits etc.

____ "Other Income Declaration Form" (If you are being supported by someone outside of the household) This form must include the approximate dollar amount of support being provided (This form must also be notarized, the clinic will provide a notary public)

Proof of Residency

____ Address Verification (Copy of Lease OR Utility Bill)

ALL documents must be dated within the last 30 days.

APPLICATIONS HOURS:

Monday – Thursday 8am-11am and 1pm-3pm
And Friday 8am-11am

Anyone who provides false information, fails to disclose all their income, or has insurance will be disqualified immediately for current and future services. We reserve the right to refuse service to anyone.

Good Samaritan Health Clinic Eligibility Form

NAME: _____ **D.O.B.** ___/____/_____ SSN**:** _____ - _____ - _____

Sex: ___Male ____Female **Marital Status:** ___Married ___ Single ___Divorced ___Widowed

Ethnicity: ___African American ___Asian ___Caucasian ___Hispanic ___Native-American ___Other

Address: _____ **City:** _____

County: _____ **State:** _____ Zip**:** _____ **Phone:** ( ) _____

Cell: ( )_____ **Work:** ( ) _____ **Email:** _____

Emergency Contact: _____

Relationship: _____ **Phone:** ( ) _____

Number of people in your household: _____ Number of people in home who work _____

Applicant's Employer: _____

If Unemployed, how long? _____

Do you currently have any private or group medical insurance? ❑ Yes ❑ No

Are you eligible for health insurance through your job or someone else's? ❑ Yes ❑ No

Are you a Veteran? ❑ Yes ❑ No Have you applied for disability? ❑ Yes ❑ No If Yes, when? _____

Have you ever applied for Medicaid? ❑ Yes ❑ No If Yes, when? _____ Were you denied? ❑ Yes ❑ No

Have you ever applied for insurance under the Affordable Care Act (Obamacare)? ❑ Yes ❑ No

Are you currently being supported by someone else who is not in your household?

If yes, who? _____. You will need to complete the

Other Income Declaration Form and it must be notarized. The clinic can provide a notary free of charge.

How did you hear about the clinic? _____

What is your reason for your establishment? _____

Is transportation to and from the clinic an issue for you? ❑ Yes ❑ No

DATE _____/_____/_____

SOURCE(S) OF INCOME

Source **Monthly Amount**

Unemployment _____ $_____

Alimony _____ $_____

Child Support _____ $_____

Food Stamps _____ $_____

Disability _____ $_____

Social Security _____ $_____

SSI _____ $_____

AFDC _____ $_____

Retirement _____ $_____

Other _____ $_____

Total Monthly Household Income $_____

Proof of Income: _____Tax Return _____ Pay Stub _____ Social Security _____ Unemployment

Other_____

Please list the information for *EVERYONE* in your household.

Name **Relationship** **DOB** **SSN**

_____

_____

_____

_____

_____

_____

_____

_____

We reserve the right to verify any and all information you have provided.

Patient Signature_____

Good Samaritan Health Clinic / Patient History

Name _____ Date _____

DOB _____ Age _____ New Patient: ❑ Yes ❑ No

Name(s) of previous healthcare provider(s):

_____

Are you allergic to any drugs? _____ I have no known drug allergies. Yes, I am allergic to: (*circle*)

Penicillin Sulfa Erythromycin Ciprofloxin Aspirin Other: _____

Reactions

Preferred Pharmacy? _____

Current Medications (*list all medications you are taking. Include over the counter, herbal, or natural remedies.*)

Medication	**Dose (mg/pill)**	**How many times per day?**

Health Concerns:

_____

_____

_____

_____

_____

_____

If disabled, check here: _____ Nature of disability _____

Signature_____ Date_____

Good Samaritan Health Clinic

Consent and Waiver Form

I have requested medical services and/or advice from medical professionals at Good Samaritan Health Clinic. In return for such services and/or advice, I agree to the following:

1. I am here of my own free will. No one forced me or required me to be here.

2. I understand that the Clinic is here to provide free medical care to those who qualify under its guidelines.

3. I believe that I qualify under the guidelines as they have been explained to me.

4. I understand, under Alabama law, I may not sue the medical professionals who provide free medical service at the clinic unless I am harmed by their "willful and wanton misconduct."

5. I further agree that I may not sue the Good Samaritan Health Clinic or Good Samaritan Health Clinic of Cullman, Inc., except under circumstances allowed under Alabama law.

6. I agree that some restrictions on my ability to sue under the Alabama law described above also apply to any medical professionals who may provide free medical services or advice to me upon referral from Good Samaritan Health Clinic.

7. I agree that I have been given this information before seeing a medical professional, and that I have been given an opportunity to ask questions I may have before signing this form.

8. I agree to give a blood or urine sample, if asked, to test for drug use.

Patient Signature Date

Power of Attorney for Social Service Advocate

To allow the Good Samaritan Health Clinic Social Service Advocate to assist you, it is necessary to obtain your signature on this form. For the sake of convenience, you may authorize an advocate of the Good Samaritan Health Clinic to speak to outside agencies on your behalf.

I, _____ (please print your full name), give my permission for an advocate of the Good Samaritan Health Clinic to speak on my behalf and obtain information regarding my Financial Assistance Application Program status through any available outside agency.

Patient Signature Date

Good Samaritan Health Clinic
Outside Health Care Agencies Agreement

I understand that I am responsible for any bills, fees, or costs at any health care agency outside of Good Samaritan Health Clinic, even though these procedures and/or tests have been recommended to me by the health care professionals at Good Samaritan Health Clinic.

Patient Signature Date

Clinic Representative Date

Power of Attorney for Medication Assistance Forms

To receive medications through the Good Samaritan Health Clinic Medication Assistance Program, it will be necessary to obtain your signature on application forms. For the sake of convenience, you may authorize an agent of the Medical Assistance Program to sign the applications for you.

I, _____ (please print your full name), give my permission for an agent of the Good Samaritan Health Clinic Medical Assistance Program to sign the applications forms for me to obtain my medications through any available patient assistance program.

Patient Signature Date

GOODSAMARITAN HEALTHCLINIC

Jeremy V. Stidham MD ♦ Patricia Calvert, CRNP
401 Arnold Street, N.E., Suite A
Cullman, AL 35055-1968
(256) 775-1389 ♦ Fax: (256) 747-5588

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To:_____

_____

_____

I hereby authorize the release/request of specified medical records pertaining to the medical and/or psychiatric treatment of the following patient to Good Samaritan Health Clinic.

PATIENTNAME:(PRINT) _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____

SPECIFIED RECORDS:
_____

_____

Expiration Date of Authorization

This authorization is effective for one (1) year unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to the Good Samaritan Health Clinic, Clinic Administrator.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the Good Samaritan Health Clinic. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____

Patient (or Representative) Signature Clinic Representative Signature

Good Samaritan Health Clinic Dental Policy

Procedures & Dental Evaluations

- If you need a dental appointment, you must call our office at (256) 775-1389.
- A dental appointment will be arranged by Good Samaritan Health Clinic at one of our local participating dentist's offices.
- The CRNP will have to examine the tooth/teeth before an appointment can be considered or referred for a dental extraction(s).
- Please be courteous and patient. All our dentists are volunteering their time and services.
- Do not call the dental office to request an appointment or walk into their office demanding to be seen; you must go through The Good Samaritan Health Clinic.
- If you cannot keep your appointment, it is your responsibility to call our office at least 24 hours in advance to cancel this appointment. Failure to do so will result in your dental appointment being delayed for at least six months. A second NO SHOW will result in your dental appointment being delayed for 12 months.
- The dentist performing dental exams or dental procedures will only extract teeth at no charge in their office. No other services will be performed at no charge.
- Please do not ask for services at no charge, other than the extraction(s) the dentist determines to be done.
- If you are seen by one of our dental providers, do not call their office for pain medication.
- You will only have 1 to 3 teeth removed in the same quadrant every 6 months. This recommendation must come from our CRNP and will not include extractions due to cosmetic purposes.

You will be scheduled for your dental appointment and notified by the staff at The Good Samaritan Health Clinic.

By signing this notice, you fully understand and agree to follow the policy and procedures for the dental appointments that Good Samaritan Health Clinic is providing.

_____ _____

Patient Signature **Date**

_____ _____

GSHC Staff **Date**

GOODSAMARITAN HEALTHCLINIC

Permission to discuss health information with family members and/or friends

Good Samaritan Health Clinic is dedicated to protecting the privacy of each patient. It is your right to receive quality care without the concern that your personal health information will be shared or disclosed with others without your permission, authorization or as otherwise permitted by law. Your medical information is protected by law and will only be used or disclosed in accordance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA).

HIPAA allows us to discuss your medical information with family members, friends, or other persons you designate who are involved in your care or payment for care. Please list your family members, significant other, or close friend(s) with whom we may discuss your medical information including your financial information.

Person	Relationship	Phone Number
Person	Relationship	Phone Number
Person	Relationship	Phone Number
Person	Relationship	Phone Number

Patient Signature Date

Clinic Representative Date

Other Income Declaration Form

Date: _____/_____/_____ Clinic Patient Number: _____

Applicant Name: _____
First MI Last

Address: _____
Street/Apt Number City State Zip

Telephone: (_____) _____-_____

Provider of Other Income/Services to Above Applicant

Provider Name: _____
First MI Last

Address: _____
Street/Apt Number City State Zip

Telephone: (_____) _____-_____

I provide the following support to the above applicant:

Housing: □ No □Yes If yes, provide the monthly amount: $_____
Utilities: □ No □Yes If yes, provide the monthly amount: $_____
Food: □ No □Yes If yes, provide the monthly amount: $_____
Transportation: □ No □Yes If yes, provide the monthly amount: $_____
Other Services: □ No □Yes If yes, provide the monthly amount: $_____
Please provide a description of other services: _____
_____

Total Monthly Amount: $_____

Provider Signature: _____
Date

Patient Signature: _____
Date

******This form must be notarized. If you need a notary public, the Clinic will provide one free of charge.***

Notary Public Information:

Authorization for Prescription Pick-Up

Name:_____ Patient ID#: _____

Phone Number: _____

I, _____give consent for the following person(s) to pick up my prescription medication from Good Samaritan Health Clinic on my behalf.

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

_____ _____

Patient Signature Date