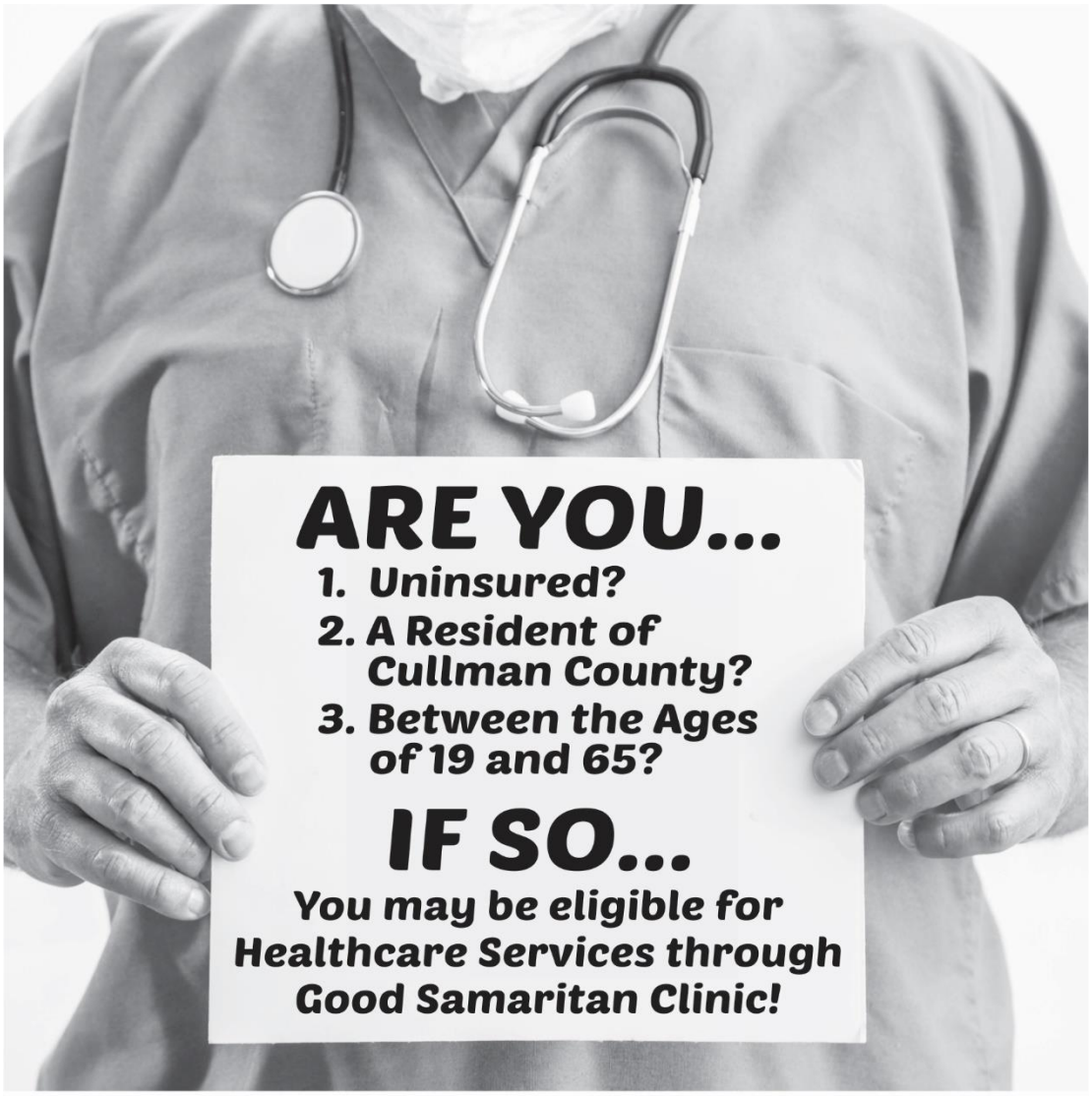

GOODSAMARITAN HEALTHCLINIC

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, Tuesday, Wednesday, Friday 800 a.m. - 4:00 p.m.; Thursday 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

____ Social Security Card with correct name
____ Alabama driver's License with correct name and address
____ Call Medicaid for Denial Letter at (256) 584-4127 (ask to have it mailed to the Good Samaritan Clinic)

Proof of ALL Household Income

____ **Federal Income Tax Return for the previous year**
W-2's will **NOT** be accepted

____ **4506-T** If you do not file taxes the clinic will provide this form

____ Paystubs 30 days prior to enrollment date for employed applicants

____ Food Stamp monthly allotment verification. This letter can be picked up at the Food Stamp Office.

____ Proof of unemployment benefits must have the maximum benefits listed.

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

____ Social Security/SSI Original Award letter. (only applies if the applicant is receiving benefits)

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

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

Proof of Residency

____ Mail with the applicants name and physical address.

ALL documents must be dated within the last 30 days.

APPLICATIONS HOURS:

Monday, Tuesday, Wednesday, & Friday 8am-11am and 1pm-3pm
Thursday 8am-11am

Anyone who provides false information, fails to disclose all of their income, or has insurance will be disqualified immediately for current and future services.
We reserve the right to refuse service to anyone. Rev 7-2020

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:** (___)_____ **Other:** _(_____)_____

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? No _____Yes _____

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

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

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

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

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_____

Other Income Declaration Form

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

Applicant Name:_____
First MI Last

Address:_____
Street/Apt Number City Zip

Telephone: (_____)_____-_____

Provider of Other Income/Services to Above Applicant

Provider Name:_____
First MI Last

Address:_____
Street/Apt Number City 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: