# 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.**

This is a check List of information required for all persons who wish to qualify as patients and patients who are re-qualifying each year. All items that apply 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**

____ **EVERYONE** in the household who has an income regardless if it is alimony, social security, child support, pension, Veteran benefits or food stamps.

____ **Federal Income Tax Return for the previous year.**
If you did not file taxes the clinic will provide a 4506-T form (Clinic has this form). If you live with someone who did file a tax return, this must be provided. No hand written tax forms will be accepted.

____ 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)

____ If you are being supported by relatives/friends, a notarized form needs to be completed.
This form must include the approximate dollar amount of support being provided (the clinic provides this form and a notary public).

**Proof of Residency**

____ Current utility bill or other piece of mail with your name on it. A Post Office Box is not acceptable.
You must provide a physical street 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 7-2016

# Good Samaritan Health Clinic Eligibility Form

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

**Sex:** ___Male ____Female **Marital Status:** ___Married ___Single ___Divorced ___Widowed

**Address:** _____ **City:** _____

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

**Cell:** (_____)_____ **Work:** (___)_____ **Other:** (_____)_____

**Emergency Contact:** _____ **Phone:** (_____)_____

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

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? _____

Do you have a lawyer representing you? No____ Yes____ Who? _____

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_____

If Yes when? _____ Were you denied? ____ Yes If No, Please explain reason you are not

insured_____

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? _____



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 allergie. Yes, I am allergic to: (*circle*)

Penicillin Sulfa Erythromycin Ciprofloxin Aspirin Other:_____

Reactions:

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**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**
**Jeremy V. Stidham MD ♦ Randa R. Duke, CRNP**
**401 Arnold Street, N.E., Suite A**
**Cullman, AL 35055-1968**
**(256) 775-1389 ♦ Fax: (256) 775-1396**

# 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 Office Manager.

**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 Date Clinic Representative Date

# GoodSamaritan HealthClinic

401 Arnold Street N.E., Suite A • Cullman, Alabama 35055
Phone: (256) 775-1389 • Fax: (256) 775-1396

**Dental Policy and Procedure:**

**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 office.
- Please be courteous and patient. All of our dentists are volunteering their 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 in advance to cancel this appointment. Failure to do so will forfeit your appointment being rescheduled.
- 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.

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

You will only have 1 to 3 teeth in the same quadrant every 6 months removed.

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

_____ _____

**Patient Signature** **Date**

_____ _____

**GSHC Staff** **Date**

United Way
of Cullman County
Funded Agency

Good Samaritan Health Clinic
401 Arnold Street, NE, Suite A
Cullman, AL 35055 ♦ (256) 775-1389

# 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: