

# 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
- \_\_\_ 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 7-2017

## 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:** \_\_\_\_\_ **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**

<i>Source</i>	<i>Monthly Amount</i>
Unemployment	\$
Alimony	\$
Child Support	\$
Food Stamps	\$
Disability	\$
Social Security	\$
SSI	\$
AFDC	\$
Retirement	\$
Other	\$
<b>Total Monthly Household Income</b>	<b>\$</b>

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.)*

<b>Medication</b>	<b>Dose (mg/pill)</b>	<b>How many times per day?</b>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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**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.

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**Patient Signature**

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**Date**

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**GSHC Staff**

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**Date**

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: