



615 North "B" Street Fort Smith, AR 72901 (479) 783-0233

Good Samaritan Clinic wants to help low-income people who work and do not have any kind of medical insurance, including Medicaid and Medicare. **People who have income that is higher than our limits will not qualify to be patients.**

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check one : [ ] Male [ ] Female Check if patient is under 18 [ ]

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Message Number ( ) \_\_\_\_\_

Cell Phone Number ( ) \_\_\_\_\_

Marital Status  Single  Married  Widowed  Separated  Divorced

Name of Spouse \_\_\_\_\_ Spouse S.S.# \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I have read the HIPAA Privacy Policies. I will allow the Good Samaritan Clinic to give information to the following person \_\_\_\_\_ Relationship to patient \_\_\_\_\_ about my medical treatment for certain reasons. These reasons include scheduling of appointments and medical consultations from the doctor, nurse or other medical personnel representing the Good Samaritan Clinic. I also give permission for the Good Samaritan staff to leave messages about my medical treatment on a message phone or answering machine.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

For Office Use Only	Fee Charge _____ %				Date last updated _____			
	W	BI	HSP	AS-PAC Is	AM-I	FHH	62+	DIS

**FINANCIAL INFORMATION**

**PATIENT EMPLOYMENT**

Do you have a job?  Yes  No    Employed  Full time  Part Time  Self-employed  Retired  Disabled

Where do you work? (list "Self" if self-employed) \_\_\_\_\_ Occupation \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

*If self-employed, you must show proof of income with bank statements, check stubs, or receipt books + last year's tax return*

If you are not working now, have you worked during the past 90 days?  Yes  No

Do you have medical insurance, Medicare or Medicaid?  Yes  No

**Is Insurance Available through Your Employer?**  Yes  No

**SPOUSE'S EMPLOYMENT**

Does someone who lives with you have a job?  Yes  No

Employed  Full Time  Part Time  Self-Employed  Retired  Disabled

Where does your spouse work? (list "Self" if self-employed) \_\_\_\_\_ Occupation \_\_\_\_\_

How long has he/she worked there? \_\_\_\_\_

*If self-employed, you must show proof of income with bank statements, check stubs, or receipt books + last year's tax return*

**Is Insurance Available through Your Spouse's Employer?**  Yes  No

**How many people live in your home?**

Number of adults: \_\_\_\_\_

Number of children: \_\_\_\_\_ (under age 18)

Total: \_\_\_\_\_

**Dependent Information**

Dependent's Name (Supported by you)	Relationship (Spouse, Son, Daughter, etc)	Date of Birth
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

U. S. Resident?  Yes  No      Did You File an Income Tax Return last year  Yes  No

Are you the Head of Household?  Yes  No

Do you receive Social Security or Disability income?  Yes  No

Date Applied \_\_\_\_\_      Date approved \_\_\_\_\_      Date Denied \_\_\_\_\_

Monthly Social Security Income \$ \_\_\_\_\_

Does your **spouse** or **child** receive **Social Security, Medicare, or Disability** Income?  Yes  No

**Total Household Income**

*Please give the following **monthly amounts***

<b>Household Income</b>	<b>Patient</b>	<b>Others</b>		<b>Patient</b>	<b>Others</b>
Salary/Wages	\$ _____	\$ _____	Retirement	\$ _____	\$ _____
Alimony	\$ _____	\$ _____	Pension	\$ _____	\$ _____
Child Support	\$ _____	\$ _____	Veteran's Pension	\$ _____	\$ _____
Public Assistance	\$ _____	\$ _____	Dividends	\$ _____	\$ _____
Other	\$ _____	\$ _____			

**Social Security Benefits**

***Patient***

Social Security \$ \_\_\_\_\_  
 Supplemental SS \$ \_\_\_\_\_  
 SSI Income \$ \_\_\_\_\_

***Spouse***

Social Security \$ \_\_\_\_\_  
 Supplemental SS \$ \_\_\_\_\_  
 SSI Income \$ \_\_\_\_\_

**Unemployment/Disability Income**

***Patient***

Unemployment \$ \_\_\_\_\_  
 Disability \$ \_\_\_\_\_  
 Workman's Comp \$ \_\_\_\_\_

***Spouse***

Unemployment \$ \_\_\_\_\_  
 Disability \$ \_\_\_\_\_  
 Workman's Comp \$ \_\_\_\_\_

To become a Good Samaritan Clinic patient, **you must bring copies of the following items: paycheck stubs for past month for everyone who lives with you, last year's tax return, Social Security notice of monthly payment, documentation for amount of unemployment, copy of checking, savings, IRA or CD accounts, proof of alimony and child support received.** Also, we receive Community Development Block Grant funds from the City of Fort Smith, so we also need proof of residence – i.e., a utility bill with your or your spouse's name.

Some drug companies have Medication Assistance Programs that give certain medications to patients who do not have money to buy their prescriptions. Every company's program is different. Each company needs certain information about the patient, the patient's financial status, the medical problem, etc. Applications for these programs must be completed accurately, and require the patient or their agent to provide this information and sign the application.

Since the majority of applications require patient signature, we are offering to sign as your agent and provide any of the above information to the drug company.

(Please initial one) **I Do** \_\_\_\_\_

**I Do Not** \_\_\_\_\_

**give permission to the Good Samaritan Clinic's Medication Assistance Program worker to sign applications for medicine on my behalf and to use the information I provided in applying for medicine on my behalf.**

\_\_\_\_\_  
**Patient or Guardian Name (please PRINT)**

\_\_\_\_\_  
**Patient or Guardian Signature**

\_\_\_\_\_  
**Date**

**All of the above information is true and correct. I understand that Good Samaritan Clinic will verify my information. I understand that if this information is found to inaccurate, I will no longer be a patient of the Good Samaritan Clinic. I agree to notify Good Samaritan Clinic within 10 days if I get medical insurance, Medicare, or Medicaid. I also agree to notify Good Samaritan Clinic if my financial situation changes.**

\_\_\_\_\_  
**Patient or Guardian Signature**

\_\_\_\_\_  
**Date**