Good Samaritan Clinic

You have taken the first step to improve your health! All services are for qualified patients only. You will receive a letter to inform you of your eligibility status. Please call the office to schedule your initial appointment if you are qualified.

- **Medical**

We DO provide:

- Office Visits
- Prescriptions (NO CONTROLLED SUBSTANCES)
- Standard Laboratory work (blood work)
- Standard X-rays
- Mental Health Counseling
- Well-woman visits (Pap & Pelvic exam)
- Mammography
- Podiatry Services
- Diabetic Education
- Limited Dermatology

We DO NOT provide:

- Emergency Room Care
- Hospitalization
- Extensive specific laboratory work ordered by an outside consultant
- Surgery
- Orthopedic Services

- **Dental**

We DO provide:

- Cleanings
- Examinations
- X-rays
- Fillings
- Extractions

We DO NOT provide:

- Root canal work
- Dental Implants, Cosmetics – Braces
- Dentures/Partials - Unless qualified for Elder Services
- Crowns
- Whitening, etc.

- **Pharmacy**

We DO provide:

- Most generic prescriptions to be filled at the pharmacy of your choice (we cannot pay for the prescriptions).
- Medications must be prescribed by one of our providers.
- Pharmacy Assistance Program (PAP) available for select medications.

We DO NOT provide:

- Controlled Substances

Good Samaritan Clinic (GSC) is a faith-based primary care clinic. There is no charge to our qualified patients (except for medications). Our caring staff is comprised of volunteers. Please DO NOT call a GSC provider at their personal office. Should you have any questions or concerns, please contact GSC.

Good Samaritan Clinic
136 East Plymouth Ave. DeLand, FL 32724
(386) 738-6990

Motivated by the love of Christ, and in obedience to His Command to serve the poor; The Good Samaritan Clinic exists to provide primary medical and dental care to the uninsured of the community through volunteer providers.

Application

Steps to Qualification:

1. **This application must be fully completed and all pertinent paperwork must be included.**
2. Bring the completed application and paperwork to the clinic on a **Monday** or **Wednesday** from **3pm to 6pm**. No appointment needed, seen on a first come first served basis.
3. Applications and documents must be submitted **IN PERSON**. We DO NOT accept applications by mail, email, or fax. You MUST meet with the Qualifier.
4. You will receive a letter to inform you of your eligibility status. If you are qualified, please call the office to schedule your initial appointment.

Documents Required for Qualification:

- Completed application
- Proof of Identification (ex: Driver's License)
- Checking/Savings Account Information
- Proof of Residency showing: current address, applicant name/spouse name (Current rent/lease contract, most recent property tax bill, a current month utility bill or service bill)
- **HOMELESS ONLY**: a current registration letter from The Neighborhood Center 434 S. Woodland Blvd. DeLand, FL 32720
- Proof of Income and Assets (bring all that apply)
    - For EACH employed household member (applicant, spouse or partner) 4 weeks of most recent pay stubs or employer verification
    - IF the household has a bank account, all pages of most recent month banking statement
    - Current SNAP (food assistance) Benefit Letter or EBT card
    - Most recent letter from Social Security showing retirement or disability benefits
    - Proof of ALL OTHER income including self-employment showing dollar amounts earned
    - If you have no income and someone supports you, the Verification of Support form needs to be completed.

Good Samaritan Clinic Application

APPLICANT NAME:_____

(first) (last) (m.i.) Maiden Name

SOCIAL SECURITY NUMBER:_____DATE OF BIRTH:_____/_____/_____

GENDER: □ Male □ Female MARITAL STATUS: □ Single □ Married □ Separated □ Divorced □ Widowed

PHONE:_____ CAN WE LEAVE A DETAILED MESSAGE □Yes □ No

EMAIL:_____CAN WE LEAVE A DETAILED MESSAGE □Yes □ No

PHYSICAL ADDRESS:_____

CITY:_____ZIP CODE:_____HOW LONG HAVE YOU LIVED HERE? _____

□ Own □ Rent □ Live with another □ Homeless

MAILING ADDRESS (if different from above)_____ CITY:_____ZIP

CODE:_____

How did you hear about Good Samaritan Clinic?_____

Do you have Medical Insurance? □ YES □ NO Do you have Dental Insurance?□ YES □ NO

If yes, select all that apply □ Medicare □ Medicaid □ VA □ WVHA Health card □ miCare

DO YOU HAVE A CHECKING OR SAVINGS ACCOUNT: □ YES □ NO

List Spouse/Partner and minor children who share your household:

FIRST AND LAST NAME	DATE OF BIRTH	RELATIONSHIP TO YOU

List ALL sources of income for the ENTIRE household, not just the applicant:

FIRST AND LAST NAME	TYPE (Paycheck, EBT, etc)	SOURCE (Employer Name, Government, etc)	$ PER MONTH

I certify that the information given by me for the purpose of qualifying for the Good Samaritan Clinic is true and correct. I understand that any misrepresentation by me in submission or omission may result in termination of Good Samaritan Clinic Services.

_____ _____

Applicant Signature Date

136 East Plymouth Ave. DeLand, FL 32724
(386) 738-6990

Applicant Name _____

NO INCOME VERIFICATION OF SUPPORT

To be completed by the individual providing financial support for applicant/household.

Name of person providing support _____

Address_____

Relationship to applicant _____

The applicant lives ☐Separate from you ☐ With you Number of persons in household_____

Your monthly household expenses (rent/mortgage, food, utilities, etc) $_____

Amount of support provided to applicant $_____

_____ _____

Signature of Person Providing Support Date