136 E Plymouth, DeLand, FL 32724

Dr. Lyle Wadsworth, Medical Director
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OUR APPLICATION

You must first apply to become a patient. Then you must reapply every year.

Appointments are always required to see a doctor or dentist. We are not a walk-in clinic.

Medical clinic hours: Monday, Wednesday, and Friday from 5 p.m. to 9 p.m.

Dental clinic hours: Monday and Wednesday from 6 p.m. to 9 p.m. Friday from 9 a.m. until noon.

As part of the application process, you must apply for the Affordable Care Act (ACA, Obamacare) to see if you are eligible. There is no cost to apply.

Applications and documents will be accepted on Monday, Wednesday, and Friday from 3 p.m. to 7 p.m. You MUST submit applications and documents in person. You will receive a letter when you are qualified. Please do not call to learn your status.

Instructions, With List of Documents Needed For Qualification

- **A fully-filled-out and signed application**

Identification (both required):
- **Valid government photo ID**
- **Social security card OR birth certificate**

Residency (choose any two from this list):
- **Rent/mortgage receipts for 3 consecutive recent months.**
- **Current rent/lease contract for rented home.**
- **Deed to owned home.**
- **Most recent property tax bill.**
- **3 consecutive recent months of dated utility bills, each with name, address, date.**
- **3 consecutive recent months of official mail, each with name, address, date.**
- **Valid vehicle registration.**
- **Recent report card for West Volusia school**
- **Our Rent Verification form, application page 5 or Support Verification, page 6.**
- **HOMELESS ONLY: registration letter from Neighborhood Center.**

Health insurance (ACA Letter of Eligibility satisfies Medicaid requirement):
- **Proof of Medicaid application. You may apply online at http://www.myflorida.com/accessflorida, or call 1-866-762-2237.**
- **Affordable Care Act (ACA, Obamacare) 13 to 20 page Letter of Eligibility. You can get this anytime, even when enrollment is closed.**

Income/assets (all that apply):
- **Recent federal personal income tax return, with W2's, OR form 4506T, verification of non-filing. We have 4506T forms. One or the other is required.**
- **Recent federal business income tax return.**
- **For each employed member of household, 8 consecutive recent pay stubs (4 consecutive recent stubs if paid biweekly), or employer verification.**
- **3 consecutive recent months of dated personal bank statements, all pages, OR a signed statement of having no bank account. One or the other is required.**
- **3 consecutive recent months of dated business bank statements, all pages.**
- **Proof of current food stamp benefit.**
- **Proof of current disability benefit (recent letter from Social Security).**
- **Our Verification of Support form, application page 6, if supported by another.**
- **Property, other than homestead (include full address and description).**
- **Cash surrender value of life insurance (if all household policies exceed $1,500).**
- **Vehicles in excess of one (include year, make, and model of other than primary).**
- **Trust funds (include value and description).**
- **Stocks, bonds, or other investment assets (include qty and description of each.**
- **If you receive income from ANY source, documentation, including amount in $.**

Good Samaritan Clinic Application

Date: ____________

First name	Last name	Initial	Maiden Name

Physical address where you live

City	County	Zip code

How long have you lived there?	Telephone

Previous address, only if less than 3 months

City	County	Zip code

Mailing address

City	County	Zip code

Date of birth	Gender, M or F	Social security number

Employer name	Paid weekly or biweekly	Gross amount per month wages

Other household members (list only spouse, partner, and minor children)
Do not list parents, grandparents, brothers, sisters, friends

Full name	DOB	Relationship	SS#
1			
2			
3			
4			
5			
6			
7			
8			

List ALL sources of income for the household, not just the applicant
Include all wages, pensions, Social Security, food stamps, disability, financial support, etc.

Full name	Income type	Income source	Monthly gross amt
1			
2			
3			
4			
5			

Good Samaritan Clinic Application

MARITAL STATUS (circle one): Married Separated Divorced Single Widowed

RESIDENCE (circle one): Own Rent Live with another homeless

DISABILITY - If you receive disability, for how many years have you received it? ___________________

FEDERAL TAX – Did your household file federal tax this recent year? (circle one): Yes No

BANK ACCOUNTS - Do you have a checking/savings account? (circle one): Yes No

PROPERTIES - If you own property other than your primary home, enter the information below:

Address	County	State
1		
2		
3		

VEHICLES - If you own more than one vehicle (auto, motorcycle, or RV), list the information of all but your primary vehicle here:

Make	Model	Year	VIN number
1			
2			
3			

TRANSPORTATION – How did you arrive here (circle one):

family vehicle other vehicle bus bicycle walked

HEALTH INSURANCE (circle all active medical or dental health insurance you have):

Medicare Medicaid Medically Needy VA WVHA Healthcard Other Medical Dental

NATURE OF AILMENT (Optional): Briefly, what medical or dental problem brings you to the clinic?

____

____

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I certify that the information given by me for 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 from Good Samaritan Clinic services.

______________________________ ______________________

Signature of applicant Date

GOOD SAMARITAN CLINIC RENT VERIFICATION

Applicant Name (print)____

I declare that I presently reside at

(address) ____.

The monthly rent is $_________. (Include cost of utilities, if provided. You **MUST** list a reasonable $ amount, even if no money changes hands. Zero or free or barter is **NOT** acceptable)

I began renting at the above location on ______________________ (approximate date)

______________________________________ ________________________

Applicant Signature Date

I certify that I have been renting the above property to

____(print applicant's name)

since ________________________(approximate date)

The monthly rent is $_________ (Include cost of utilities, if provided. You **MUST** list a reasonable $ amount, even if no money changes hands. Zero or free or barter is **NOT** acceptable)

Rentor/lessor name ____

(print)

Relationship of rentor/lessor to applicant: ________________________ **(Do not enter current spouse, partner, or minor child of applicant, since they are members of applicant's household)**

Rentor/lessor address____

Rentor/lessor phone ______________________________________

I, the undersigned, do hereby swear that the information contained herein is true and correct.

______________________________________ ________________________

Rentor/Lessor signature Date

Optional - Need not be notarized if used

Verification of Support

Section below to be filled in by applicant

Date:	Applicant Name:	Date of Birth:	Last 4 Digits of SSN:

Physical Address:

City:	Zip:

I have been residing at the above address since approximately: ______________________________________

If less than 3 months, my previous address was:

My food and/or living expenses are provided by (name): ____

Applicant Signature:	Date:

Section below to be filled in by support provider

Does the applicant reside with you? (circle one): Yes No

My monthly household expenses are (include rent, food, utilities): $ __________________

How many persons live in this residence?: __________________

In addition to household expenses, I provide $ ____________ monthly to the applicant.

Support Provider Name (print):

Support Provider Address (print):

Support Provider Relationship to Applicant: ___________________________

Support Provider Signature:	Date:

OPTIONAL, BUT MUST BE NOTARIZED IF USED