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, Wednesday or Friday from 3PM to 7PM. 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

‣Valid Government Issued Photo ID (ex: Driver's License)

► Checking/Savings Account Information

► Proof of Residency showing: current address, applicant name/spouse name (Bring one of the following)
‣ Current rent or lease contract for rented home -or-
‣ Most recent property tax bill for owned home -or-
‣ A current month utility bill or service bill -or-
‣**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) previous month pay stubs or employer verification
‣ IF 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:_____

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

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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