ELIGIBILITY SCREENING REQUIREMENTS

To determine your eligibility, you must bring **ALL** the required documentation below at the time of your appointment or we will not be able to screen you. We do not accept any documentation or applications through email or fax. To be screened you must schedule a screening appointment. Please note that eligibility screening appointments have **NO TOLERANCE FOR NO SHOWS**. To better assist you with questions or concerns please call our office 48 hours in advance during business hours at 512-331-5828 to reschedule your Eligibility appointment if needed.

Please ensure you have the following supporting documentation to accompany your application:

- **Identification:** We can only accept valid and non-expired photo identification that is issued by your state/country/region. We do NOT accept copies of identification.
- **Proof of income (Applicants must provide one and/or of the following for income) :**

-Paid Bi-weekly: 4 most recent pay stubs

-Paid Weekly: 6 most recent pay stubs

-Paid Monthly: 3 most recent paystubs

-6 most FULL recent bank statements

-Self Employers must provide recent Federal Tax Return or your current year of recent 1099 form and or 3-6 months of bank statements.

***Applicants with non-documented pay must provide a statement from employer on a company letterhead form and company address and phone number. ** Applicants that get financial support from another party must provide a Statement of financial support from Samaritan Health Ministries with supporting documents that is required. ***

- **Established Residency:** Your recent water/gas/utility/lease bill that will need to be in your name.
- ***Applicants that live with someone else and that cannot provide a recent bill in your name because of this reason you will need to provide a Statement of Residency form from Samaritan Health Ministries with supporting documents.*

********** **OFFICE USE ONLY********** ***PATIENT ID:*** _____

- ❑ **ELIGIBLE** for services at Samaritan Health Ministries that will expire on: _____must be renewed by: _____.
- ❑ **INELIGIBLE** for services at Samaritan Health Ministries and provided additional information to the applicant for other resources that may be better of assistance to the applicant.

★ ***Mark one of the below for WILCO information:***

- ❑ Provided WILCO Letter
- ❑ Has not provided WILCO Letter and/or needs to complete going through the WILCO process
- ❑ Applicant is unable to go through WILCO process

APPLICANT INFORMATION * REQUIRED

Name: _____ **Date:** _____
First Name Last Name Middile Initial/Suffix

SSN: _____-____-_____**Date of birth:** ___ / ___ / _____**Gender Identity:** _____

Address: _____ _____ _____ _____
Street Address APT # CITY State Zip Code

County: ☐ *Williamson County* ☐ *Travis County* ☐ *Other* _____

Mobile phone: (____)_____ Home/Work phone: (____)_____

An email is required; each applicant must provide their own email Email: _____

Citizen Status: ☐ *Legal Citizen* ☐*Non Legal Citizen* ☐ *Refugee*

Preferred Language:☐English ☐Spanish ☐OTHER _____

Are you a veteran: ☐ **Yes** (*If you marked yes, please do not continue the application)*
☐**No** (*Please continue completing the application)*

Marital Status:☐*Single/Never Married* ☐ *Married* ☐ *Divorced/Separated/Widowed*

Ethnicity :☐ Hispanic or Latino ☐ Non-Hispanic/ Non-Latino

Race : ☐ Asian ☐ African American/Black ☐ Caucasian ☐Native American ☐ Other _____

Work Status :☐ Unemployed ☐ Self Employed ☐ Full-Time ☐ Part-time ☐I get financial assistance
If you receive financial assistance, how much do you get monthly? **$ _____/mos**

☐ *Disabled (If you are collecting SSI/SSDI you will need to apply for Medicaid, do not continue the application. More documentation is required if you collect SSI/SSDI)*

APPLICANT EMERGENCY CONTACT			
First Name	**Last Name**	**Relationship**	**Phone number**

Release of Medical Information

Do you authorize another party to collect any of your medical information or pick up any prescriptions?

☐ **Yes** (*If you marked yes, please complete the information below)*

☐**NO** *(Please skip this section of Release of Medical Information)*

Authorization to Release Medical Information to:

First Name	Last Name	Relationship	Phone number

This section of *RELEASE OF MEDICAL INFORMATION* provides authorization as indicated above. We at Samaritan Health Ministries pride ourselves in protecting the privacy of our applicants/patients. Do not sign this section if you do not authorize our clinic to release any of your information. Information about you cannot be released to others without your consent, except as authorized by law.

I understand,

Print Name: _____ Applicant Signature: _____ Date: _____

INCOME DECLARATION AND FRAUD STATEMENT

APPLICANT INFORMATION	
Applicant Name:	Date:
SSN:	DOB:

FRAUD STATEMENT

I, _____, hereby affirm that the income is correct and verified if necessary. If my income should change, due to loss of a job, new employment or income received from any source, I agree to report the changes to Samaritan Health Ministries.
I understand the information provided here will be verified. I also understand that failing to report employment or income from any source could result in civil or criminal penalties. I may **also be held responsible for FULL PAYMENT for any medical services received at Samaritan Health Ministries.**

SIGNATURES	
Applicant Name (PRINTED):	DATE:
Applicant Signature:	

OFFICE USE ONLY					
Total household income		Monthly		Annually	
Occupation:					
How many members in household (18+ yrs):		Number of dependents in household:			
Patient's Initials:	Screener's Initials:		Date Screened:		

SAMARITAN HEALTH MINISTRIES

CONSENT AND POLICIES

1. I understand Samaritan **Health Ministries (SHM)** is here to provide *FREE medical, dental and mental health care to patients who qualify under its guidelines.*

2. I understand medical, dental, and other health-related services at SHM are provided by licensed and certified health care professionals, including physicians, resident physicians, and dentists, as well as alternative health providers, including nurse practitioners, nurses, physician assistants, social workers, and psychologists. ***I understand that I have the right to request to see a doctor instead of an alternative health care provider.***

• *I must update my contact information with the clinic should there be any changes*. (**INITIALS**)_____

• *I must request medication refills 2 weeks* **BEFORE** *my medication ends*. (**INITIALS**)_____

• *It is my responsibility to sign the Prescription Assistance Program (PAP) drug formularies and inform* **SHM STAFF 4 WEEKS** b*efore my medication runs out*. (**INITIALS**)_____

• It is my responsibility to have the necessary blood tests and imaging done within **7 DAYS BEFORE** my appointment. (**INITIALS**)_____

3. I understand that ***SHM abides with federal HIPAA confidentiality rules and regulations***. I understand that my medical and dental information will be used and shared between the medical and dental areas within SHM. I also understand that I may request a copy of SHM's HIPAA disclosure at any time by requesting a copy from front desk staff. (**INITIALS**)_____

4. I understand that *SHM may communicate with me via text message to my phone, leave voicemails, and send emails*. (**INITIALS**)_____

5.**NO SHOW POLICY:**

- •I must notify the clinic **48 business hours** in advance to cancel any of my appointments so that my appointment space can be filled by another patient. If the appointment is not cancelled **48 business hours** in advance, it will be considered a NO-SHOW. (**INITIALS**)_____
- • If I do not attend my appointment, it will be considered a NO-SHOW, 3 NO SHOWS in a year, I will be placed ineligible for continued services for the remainder of my current services. (**INITIALS**)_____
- • If I am more than **10 minutes** late for my appointment, my visit will be cancelled and will be considered a NO-SHOW. (**INITIALS**)_____

6.**TELEMED APPOINTMENT CONSENT: In** case the provider is unavailable in person, I have the option to be seen via telemedicine.

_____***I agree*** to participate in telemedicine visits with my provider through VIDEO and AUDIO

_____***I do not agree*** to participate in telemedicine visits with my provider through AUDIO and VIDEO

7.As a SHM patient, I understand that I need to go to the hospital emergency room if I have a medical emergency (**INITIALS**)_____

8. If necessary, in my care, I consent to my SHM provider accessing my medication history. (**INITIALS**)_____

9.I understand that SHM services are provided regardless of race, residence, religion, sex, age, national origin, color, sexual preference, or contraceptive preference. (**INITIALS**)_____

10. I authorize my photo/video to be taken by staff, volunteers, or others while participating in clinic activities. ***Yes*** _____ ***No*** ____

11.- I understand my records are confidential. I have read and agreed to Samaritan Health Ministries' Patient Privacy Practices which explain how my records will be handled. (**INITIALS**)_____

I understand the above information and voluntarily request and consent to this clinic's services (tests, treatments, procedures, and other services as directed) for myself or the minor I am accompanying. I understand that this consent is valid until revoked in writing. (**INITIALS**)_____

SIGNATURES	
Applicant Name (PRINTED):	DATE:
Applicant Signature:	

*****If the applicant is under the age of 18 the person accompanying the minor must sign and date below authorizing that the information completed is truthfully and understood by both parties. *****

SIGNATURES	
Accompanying Adult Printed Name:	DATE:
Accompanying Adult Signature:	

ELIGIBILITY POLICIES AND CONSENT

Due to the high volume of applicants, we cannot guarantee prompt services. We strive to review each applicant according to the way it is received. At Samaritan Health Ministries we can offer other resources that may be available to you. Please note that all applicants must complete our screening process. Within our screening process we request certain criteria and documentation to determine eligibility. We pride ourselves in protecting all our applicants' privacy under the compliance of HIPPA. Please note that the documentation that we request prior to being screened is to ensure we are providing you with the proper resources that can better serve you. *Please note that all eligibility screenings are by appointment ONLY*. If you are scheduled for a screening appointment, we require that all ELIGIBILITY *DOCUMENTATION* is brought with you at the time of your appointment. If you are unable to bring all your required documentation, we will reschedule your screening appointment, and this may cause a longer delay of your eligibility determination and services from our clinic. If you are scheduled for a screening appointment and you cannot keep it, this will be considered a (NO-SHOW). Our eligibility screening appointments have a *NO TOLERANCE OF NO-SHOW POLICY*. Not attending any eligibility screening appointments will cause a longer delay in being screened for eligibility at our clinic and receiving services from our clinic.

*We kindly thank you for choosing Samaritan Health Ministries and entrusting our staff to better serve you. Thank you for your continued support and understanding of our policies. We look forward to continuing to better serve y*ou and Greater Will*iamson County Residents.*

SIGNATURES	
Applicant Name (PRINTED):	DATE:
Applicant Signature:	

If the applicant is under the age of 18 the person accompanying the minor must sign and date below authorizing that the information completed is truthfully and understood by both parties. *

SIGNATURES	
Accompanying Adult Printed Name:	DATE:
Accompanying Adult Signature:	

Patient Bill of Rights at Samaritan Health Ministries

At Samaritan Health Ministries, we believe that the protection and support of the basic human rights of freedom of expression, decision and action are important to the healing and well-being of our patients and clinic. Therefore, we strive to treat patients with respect and with full recognition of human dignity. Decisions regarding health care treatment will not be based on race, creed, sex, national origin, age, disability, or sources of payment.

1. You have the right to a reasonable response to your request and need for treatment or service, within the Facility's capacity, its stated mission, and applicable laws and regulations.

2. You have the right to be informed about which physicians, nurses and other health care professionals are responsible for your care.

3. You have the right to the information necessary for you to make informed decisions, in consultation with your physician, about your medical care including information about your diagnosis, the proposed care and your prognosis in terms and a manner that you can understand before the start of your care. You also have the right to take part in developing and carrying out your plan of care.

4. You have the right to consent to or refuse medical care, to the extent permitted by law, and to be told of the risks of not having the treatment and other treatments which may be available.

5. You have the right to reasonable access to care. Although the Facility respects your right to refuse treatments offered to you, the Facility does not recognize an unlimited right to receive treatments that are medically ineffective or non-beneficial.

6. You have the right to care that is considerate and respectful of your personal values and beliefs. The Facility strives to be considerate of the ethnic, cultural, psychosocial, and spiritual needs of each patient and family.

7. You have the right to have your family take part in your care decisions with your permission.

9. You have the right, to the extent permitted by law, to have your legal guardian, next of kin, or a surrogate decision maker appointed to make medical decisions on your behalf in the event you become unable to understand a proposed treatment or procedure, are unable to express your

wishes regarding your care, or you are a minor. The person appointed has the right, to the extent permitted by law, to exercise your rights as a patient on your behalf.

10. You and your appointed representative have the right to take part in ethical questions that arise during your care.

11. You and your legal representative have the right to access the information contained in your medical record in a timely manner subject to state and federal law.

12. You have the right to personal privacy and for your medical information to be kept confidential within the limits of the law.

13. You have the right to receive care in a safe setting.

14. You have the right to be free from abuse or harassment.

15. You have the right to have your pain assessed and managed properly and to receive information about pain and pain relief measures.

16. You have the right to obtain information concerning the relationship of the Facility to other health care Facilities as they relate to your care.

22. You have the right to submit a complaint to the Facility regarding your care or regarding any belief you have that you are being discharged too soon. Your care will not be affected by submitting a complaint. The steps for doing so are at the end of this statement.

Your Responsibilities as a Patient

Your contribution to your health care is vital, and you can be involved in the health care process by fulfilling certain responsibilities. As a patient, it is your responsibility to:

1. Provide correct, complete information about your medical condition and any past or current medical treatment.

2. Ask questions or acknowledge when you do not understand the treatment course or care decision.

3. Follow the treatment plan recommended by your physician and other health care professionals. If you choose not to follow your treatment plan, you are responsible.

4. Discuss with your doctor and nurse what to expect regarding pain and pain management relating to your illness, including

a) options for pain relief

b) potential limitations and side effects of treatment for pain, and

c) any concerns you have about taking pain medicines. It is your responsibility to ask for pain relief when pain begins and to tell your doctor or nurse if your pain is not relieved.

5. Be considerate and respectful of other patients, Facility employees and your physicians. 6. Follow Facility rules regarding the conduct of patients, including smoking.

7. Aggressive behavior will not be tolerated. The clinic has a DISRUPTIVE PATIENTS POLICY PROTOCOL. You may request a copy of this policy at your discretion. At any time, the clinic can dismiss patients from continuing services at Samaritan Health Ministries clinic and or any future events should the clinic feel this policy is being abused. Please note that we implement these policies to protect our patients and staff in our clinic. Our goal is to continue to provide the best services of our ability within a safe environment.

Please sign our Patients' Bill of Rights agreement agreeing that you understand our policies and procedures.

If you do not agree with the information above, please do not sign, and our clinic can assist you with further information to better serve you.

****

I understand and agree with Samaritan Health Ministries Patients' Bill of Rights,

PRINT NAME: _____

SIGNATURE: _____

Date: _____

Thank you for choosing Samaritan Health Ministries. We look forward to serving you.

For your convenience we have attached some forms and detailed information that may be something you will need to provide to us. (We cannot accept any emailed documentation or screenshots)

If you are unemployed and being financially supported by someone else, you will need to provide:

*__Statement of Financial Support__ (You can find this form below. This form would need to be completed and notarized. *You will also need to provide financial information for the person that is financially supporting you that may include one of the following:*

-Paid Bi-weekly: 4 most recent pay stubs

-Paid Weekly: 6 most recent pay stubs

-Paid Monthly: 3 most recent paystubs

-3-6 months of FULL recent bank statements

-Self Employers must provide recent Federal Tax Return or your current year of recent 1099 form and or 3-6 months of bank statements.

If you are currently living with someone else who provides shelter to you, you will need to provide:

Statement of Residency (You can find this form below. This form would need to be completed and notarized. You will also need to provide proof of residency for the person that is providing residency to you that may include one of the following:

Recent water/gas/utility/lease bill that will need to be in the name of the person that is providing you residency.
If you have questions about the documentation, please contact our clinic during business hours.

Samaritan Health Ministries: 512-331-5828
Business Hours: 8am- 4pm (Monday- Friday)

Statement of Financial Support

This form is to be completed by the person providing financial support to the applicant.

I,(Financial supporter full name) _____provide financial support to,

(Applicant Full Name) _____ who is currently unemployed.

I provide financial assistance with my sufficient income to pay for the applicant's expenses

From (Best estimate date): _____through _____.

I, the financial supporter currently provides financial support to the applicant above in the amount of

$ _____ (Please circle one) Month/ Week/ Hour/ Yearly

I have provided all my required proof of documentation and income that may determine eligibility for the above applicant at Samaritan Health Ministries.

This section below is to be completed and signed by a notary public

Sworn to (affirmed) and subscribed before me this_____ day of _____,20 _____

Supporters Name _____ and Signature _____

Applicant Name _____ and Signature _____

Notary Signature _____

Notary Printed Name _____

(Notary Seal)

Statement of Residency

This form is to be completed by the person providing shelter support to the applicant.

I,(Residences Name) _____provide residency support to,

(Applicant Full Name) _____ who is currently residing with me at

(Physical address): _____ who has lived here

From (Best estimate date): _____through _____.

I have provided all required proof of documentation and residency information that may determine eligibility for the above applicant at Samaritan Health Ministries.

****This section below is to be completed and signed by a notary public****

Sworn to (affirmed) and subscribed before me this_____ day of _____,20 _____

Supporters Name _____ and Signature _____

Applicant Name _____ and Signature _____

Notary Signature _____ Notary Printed Name _____

(Notary Seal)