ST PAUL MEDICAL CLINIC

1120 Randlett St
Lancaster, TX 75146
(945) 279-6750
https://www.stpaulclinic.org/newpatient

Service at St. Paul Medical Clinic (SPMC)

St. Paul Medical Clinic provides low-income, uninsured, underinsured, and medically underserved individuals with healthcare services at little or no cost. If you are in need of medical services and you (1) reside in north Texas, (2) do not have health insurance coverage of any kind or are underinsured, and (3) meet the income requirements, we may be able to help.

Applying for Service

Each patient of SPMC must apply for service and show that you meet the above criteria. **PLEASE read each page of the intake form carefully and complete each form as completely as possible.**

There are three ways to submit your application:

1. **Print and Complete By Hand**
   Please scan and email to **info@stpaulmed.org**. Or fax to **(945) 279-6751**.
2. **Download and Complete on Computer**
   Download and SAVE your completed form to your computer. Then attach and email to **info@stpaulmed.org.**
3. **Apply by Phone**
   Call during office hours to submit an application if you do not have access to a computer. Office hours can be found at the clinic website - https://www.stpaulmed.org.

Accepted Patient Documents

To complete your application, you must provide one (1) type of documentation from each of the columns below. When submitting your application, remember to attach copies of each document to your email.

Proof of Identity	Residence	Income
Any Identification with the patient's name and photo: 1. Driver's License 2. State Issued I.D. 3. Passport 4. International I.D. 5. School I.D.	Any Mail in the patient's name with their current address: 1. Driver's License 2. State Issued I.D. 3. Mortgage Agreement 4. Contract Lease (Current/Last year) 5. Utility Bill 6. Auto Insurance 7. Treatment Program I.D. as verified by your case manager (can be a letter) 8. Hardship Referral Letter	Proof of Income which covers your monthly expenses, and shows you earn at or less than 300% of the Federal Poverty Level for your household size. 1. Tax return 2. The most recent month's paystubs 3. Letter from employer, detailing wage and hours **If you do not work:** 1. Statements from income source: Social Security, Child Support, Food Stamps, Retirement or Disability 2. Hardship Referral Letter

If you have questions, call the clinic at (945) 279-6750 and we can help you!

ST PAUL MEDICAL CLINIC

Primary Language: _____

Patient Information

Every Patient must complete this form

First Name	MI	Last Name	SSN/ITIN:	Date of Birth (mm/dd/yyyy)

Address	City	State	Zip

Primary Phone #	Gender	Marital Status
	☐ M ☐ F	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity
☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian/White ☐ Native American ☐ Other:

Education Completed
☐ None ☐ Elementary School ☐ High School/GED
☐ 2 Years College ☐ 4 Years College

Employment
☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired
☐ Disabled ☐ Student ☐ Other:

How did you hear about St. Paul Medical Clinic?
☐ Radio ☐ TV/News ☐ Internet/Website ☐ Church
☐ Other:

# of People in Household: _____ Please list names and dates of birth for each person living with you:

	Name	DOB	Employed	Relationship
1)	_____	_____	Y ☐ / N ☐	_____
2)	_____	_____	Y ☐ / N ☐	_____
3)	_____	_____	Y ☐ / N ☐	_____
4)	_____	_____	Y ☐ / N ☐	_____
5)	_____	_____	Y ☐ / N ☐	_____
6)	_____	_____	Y ☐ / N ☐	_____

Medical and Prescription Information

Health Insurance
☐ None ☐ Medicare ☐ Medicaid ☐ VA Benefits
☐ Other:

In the last 12 months, have you been admitted to the hospital or visited an emergency room for your condition?
☐ Yes ☐ No If yes, how many times? _____

Medication(s) Needed:

Please list Allergies to medications and your reaction:

Patient Income and Expenses

List Household Income:

Salary/Wages	$_____
Disability	$_____
Alimony/Child Support	$_____
Social Security	$_____
Pension/Retirement	$_____
Unemployment/ Work Comp	$_____
Unearned Income	$_____
Gross Monthly Income	**$_____**
Total Gross Annual Income	**$_____**

List Monthly Household Expenses:

Rent/Mortgage	$_____
Utilities (Electricity, Water, etc.)	$_____
Food	$_____
Basic Needs (Clothing, Hygiene)	$_____
Total Household Expenses	**$_____**

If someone else pays for your living expenses, please have them complete the Hardship Referral Letter on your behalf.

Terms of Service Agreement

Every Patient must complete this form. Please read carefully and add your initials to each section. Your initials mean that you have read, understand and agree to each statement.

_____ **Terms of Qualification for Service**
I understand the terms concerning qualification for service at St. Paul Medical Clinic (SPMC). I understand that there is no fee ($0) for any services I receive. I also understand that I have been certified for up to twelve (12) months, and that I must resubmit verification of my qualification for service at the end of that time to continue receiving medical services.

_____ **Consent to Treatment by Volunteers**
I understand that services I receive from SPMC may be provided by a volunteer which is not administered for or in expectation of compensation. I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer, including immunity from civil liability for any act or omission resulting in death or injury to a patient.

_____ **Change of Information Agreement**
I acknowledge that I will report any change of address, insurance status or income to SPMC immediately. I understand that any changes may affect my qualification for service at the clinic.

_____ **Consent and Release**
I understand that any information I provide to SPMC will be kept confidential. However, I hereby authorize SPMC to share my information, including but not limited to my name, address and other personal information with other medical facilities and/or pharmaceutical manufacturers participating in my care in order to coordinate services. I also authorize SPMC to share my information, including eligibility and prescription records, with any Pharmaceutical Manufacturers Patient Assistance Program(s), or their designee, for which I qualify, for auditing purposes. I understand that this consent is authorized for twelve (12) months from the date signed below, and that I may revoke this consent at any time by submitting a request in writing to SPMC, except when action has already been taken to obtain and/or release such information.

_____ **Permission to Release Information for Patient Assistance Program Qualification**
I also authorize St. Paul Medical Clinic to use my information, including prescription records, to assist me in finding any Patient Assistance Program(s) for which I qualify, in order to assist me in accessing these programs, and to coordinate services.

I attest that all information submitted in this application is true to the best of my knowledge. By my signature, I indicate that I understand and agree overall to the terms and conditions of service at St. Paul Medical Clinic. If the patient is a child under the age of 18, I sign as their legal guardian.

Patient's Name Print _____ **Date** _____

Patient's Signature _____ **Date** _____
(Or Signature of legal guardian)

Hardship Referral Letter *(optional)*

Please complete this form if someone besides your spouse supports you by providing housing or paying for your expenses. ***This letter must be completed by the individual or organization who provides support for you.***

RE: St. Paul Medical Clinic:

To Whom It May Concern,

This letter is to verify that I or my organization is supporting _____ in the following way(s):

☐ By currently providing full financial support for his/her basic needs and expenses, due to him/her not receiving enough or any income to cover them.

☐ By providing housing support because they lack a fixed, regular and adequate living arrangements,

☐ By attesting that this person is self-employed and their income is sporadic. This person gets paid in cash and their estimated weekly income is _____.

☐ By attesting that this person has no income and is currently homeless.

☐ By supporting them in their attempt to flee domestic violence, dating violence, sexual assault, stalking or other dangers or life-threatening conditions that relate to violence against the individual or a family member.

I can also confirm that the patient resides at _____.
Patient's Address

I attest that this information is true to the best of my knowledge. I can be contacted for any questions or further investigation at the information provided below.

Sincerely,

Supporter/Individual/Organization Name _____

Signature_____

Phone _____ **Date** _____

Income Qualifications

The chart below shows the National Federal Poverty Level for 2023. (Source: https://aspe.hhs.gov/poverty-guidelines) St. Paul Medical Clinic is able to serve residents of Texas whose income is less than 3x the Federal Poverty Level for their household size.

Family Size	300%
1	$43,740
2	$59,160
3	$74,580
4	$90,000
5	$105,420
6	$120,840
7	$136,260
8	$151,680

If you aren't sure whether your income qualifies, you have no income, or you have questions, call the clinic at **(945) 279-6750** or email the clinic at **info@stpaulmed.org**.