Application Instructions

ELIGIBILITY REQUIREMENTS

1. Florida Keys resident for at least 6 months
2. Meet income level restrictions (see Gross Income Eligibility Criteria)
3. No health insurance of any kind
4. At least 18 years old

REQUIRED DOCUMENTS

1. **Completed Application**
   (A separate application for each household member seeking services)

2. **Identification**
   (Driver License, State ID, passport, etc.)

3. **Proof of Address**
   (Provide ONE of the below IF your ID does not have current address)

   - Deed or current mortgage statement
   - Copy of current lease -- OR -- NOTARIZED letter from landlord stating address and monthly rent
   - 2 pieces of official mail (from bank, utility company, government agency, etc.)
   - If you are homeless, speak to the Good Health Care Clinic Staff

4. **Proof of Income**
   (Provide ALL of the below)

   - Current Income Tax Return for all adult members of your home
     - If you did not file taxes, provide a NOTARIZED letter stating you did not file taxes and are not claimed as a dependent
     - If you are a dependent, provide Tax Return of your financial supporter
   - Most recent month of pay stubs from all employers
     - If you are paid in cash, provide a NOTARIZED letter stating income per month and services you are paid for
   - Documentation for all social services or government income you receive
     (social security, welfare, SNAP, etc.)

Upon review, additional documents may be required.

2016 Gross Income Eligibility Criteria

Patients may make up to the below income levels to be accepted as a GHC patient.
SSI is not counted towards below totals.

Family Size	Annual Income	Monthly Income
1	$23,760	$1,980
2	$32,040	$2,670
3	$40,320	$3,360
4	$48,600	$4,050
5	$56,880	$4,740
6	$65,160	$5,430
7	$73,460	$6,122
8	$81,780	$6,815
9	$90,100	$7,508
10	$98,420	$8,202

For questions, contact a Good Health Clinic Patient Care Coordinator.
Applications may be submitted by email, fax or in person at the Good Health Clinic.

91555 Overseas Hwy, Suite 2, Tavernier, FL 33070
Tel: (305) 853-1788
Fax: (305) 853-1789
info@thegoodhealthclinic.org
Monday – Friday 9:00 am - 3:00 pm
Closed for lunch 12:30 pm - 1:30 pm

PATIENT APPLICATION

Application Date: _____

Name: _____
(Last) (First) (MI)

Date of Birth: ____/___/____ Social Security #: _____

Have you been a Good Health Clinic patient before? Yes No If yes, date of last application: _____

Primary Language? English Spanish Do you need an interpreter? Yes No

How did you hear about the clinic? Newspaper Existing/Previous patient Employer/Coworker

GHC employee Mariners Hospital Other: _____

Please list all addresses in the last 6 months.

Address: _____City:_____ State:____ Zip:_____

How long have you lived here? _____ (if less than 6 months please provide previous address)

Address: _____City:_____ State: ____ Zip:_____

How long have you lived here? _____

Phone #: _____ Cell #: _____

Email: _____
(We would like to keep you connected by sending you the Good Health Clinic newsletter!)

Emergency Contact:

Name: _____ Relationship: _____Phone #: _____

Are you seeking medical care as a result of an accident? YES NO If yes, please explain. _____

_____.

Do you have a lawyer related to accident? YES NO

Occupation: _____
CURRENT employers:

Employer #1: _____ Employer phone #: _____

Position: _____

Employer #2: _____ Employer phone #: _____

Position: _____

OTHER INCOME:

Pension	$_____	Aid to Dependent Children	$_____
Vet Pension	$_____	Dade County Public Assistance	$_____
Social Security	$_____	Old-age Assistance	$_____
Social Security – Disabled	$_____	Aid to the Blind	$_____
Supplemental Security Income	$_____		
Workers' Compensation	$_____	Alimony	$_____
Unemployment Compensation	$_____	Child Support	$_____
Rental income	$_____	Other (specify):	
Investments	$_____	_____	$_____
Interest Income	$_____		
Stocks/Bonds	$_____		
Dividends	$_____	**Total:**	**$_____**
Cert of Deposits	$_____		

MONTHLY EXPENDITURES:

Mortgage/Rent	$_____	Medical Premiums	$_____
Telephone	$_____	Medications	$_____
Electric	$_____	Misc. Expenses (specify)	
Water	$_____	a. _____	$_____
Car Payments	$_____	b. _____	$_____
Auto Insurance	$_____		

OUTSTANDING DEBT:

	Balance Owed	Monthly Payments
1.	$	$
2.	$	$
3.	$	$

APPLICANT STATEMENT OF VERACITY AND COMPREHENSION

By signing below the applicant attests all information submitted on the application and supporting materials provided are true and accurate. The applicant agrees that in the event any material omission, misstatement or misrepresentation is identified concerning this application, the applicant will be liable for all costs associated with services provided by the Good Health Clinic and its affiliates for the duration this application was considered active. The applicant will also be responsible for any attorney fees and costs incurred by The Good Health Clinic in the enforcement of this agreement.

_____

Applicants Signature **Date**

_____

Witness Signature **Date**

The Good Health Clinic
Great Care — Free Care

(Witness must watch applicant sign document!)

Florida HEALTH

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER:

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____NO _____
Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults____ Under 18 ____ **18-21--Student ____** **Unborn _____** **Family Size TOTAL _____**

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			**$**	**$**
SPOUSE/PARTNER			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
		TOTALS	**$**	**$**
		Add earned and unearned income to determine total		**TOTAL INCOME $_____**

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $_____ (Total)

Section 4 **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

_____ _____

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE

PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

(VALID FOR ONE YEAR) Expiration date: _____

DH 1032E (12/14), 64I-2.002(4), F.A.C.