

# Application Instructions

## **ELIGIBILITY REQUIREMENTS**

1. Florida Keys resident
2. Meet income level restrictions (see Gross Income Eligibility Criteria)
3. No health insurance of any kind

## **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.**

## 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	Average Monthly Income
1	\$ 2,010
2	\$ 2,707
3	\$ 3,403
4	\$ 4,100
5	\$ 4,797
6	\$ 5,493
7	\$ 6,190
8	\$ 6,887
9	\$ 7,583
10	\$ 8,280
For each additional person add	\$ 697

**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](mailto:info@thegoodhealthclinic.org)

Monday – Friday 9:00 am – 4:30 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: \_\_\_\_\_

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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!)

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## Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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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

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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	\$ _____
		Other (specify):	
Rental income	\$ _____	_____	\$ _____
Investments	\$ _____		
Interest Income	\$ _____		
Stocks/Bonds	\$ _____		
Dividends	\$ _____		
Cert of Deposits	\$ _____		
		<b>Total:</b>	\$ _____

**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**

**(Witness must watch applicant sign document!)**



**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			\$	\$
<b>TOTALS</b>			\$	\$
Add earned and unearned income to determine total				<b>TOTAL INCOME</b> \$ _____

**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: \_\_\_\_\_