Good Health Clinic

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.

Good Health Clinic

2023 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	$ 2,430
2	$ 3,287
3	$ 4,143
4	$ 5,000
5	$ 5,857
6	$ 6,713
7	$ 7,570
8	$ 8,427
9	$9,283
10	$ 10,140
For each additional person add	$ 857

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.

Tavernier Office:
91555 Overseas Hwy, Ste. 2, Tavernier, FL 33070 Phone: 305.853.1788

Marathon Office:
5800 Overseas Hwy, Suite #36, Marathon, FL 33050 Phone: 305.946.1314

Fax: 305.853.1789 **Email**: info@thegoodhealthclinic.org

Good Health Clinic

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 $________
Vet Pension $________
Social Security $________
Social Security – Disabled $________
Supplemental Security Income $________
Workers' Compensation $________
Unemployment Compensation $________

Rental income $________
Investments $________
Interest Income $________
Stocks/Bonds $________
Dividends $________
Cert of Deposits $________

Aid to Dependent Children $________
Dade County Public Assistance $________
Old-age Assistance $________
Aid to the Blind $________

Alimony $________
Child Support $________

Other (specify):
________________________ $________

Total: $________

MONTHLY EXPENDITURES:

Mortgage/Rent $________
Telephone $________
Electric $________
Water $________
Car Payments $________
Auto Insurance $________

Medical Premiums $________
Medications $________
Misc. Expenses (specify)
a. _______________ $________
b. _______________ $________

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**

Good Health Clinic

(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			**$**	**$**
		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: ______________________________