

### **ELIGIBILITY REQUIREMENTS**

- Florida Keys resident
- No health insurance of any kind
- Meet income restrictions

Eligibility is not influenced by race, sexual orientation, home ownership, marital status, citizenship status, or inability to provide payroll or IRS documentation.

#### 2024 Patient Income Maximums

Family Size	Monthly Income			
1	\$ 3,765			
2	\$ 5,110			
3	\$ 6,455			
4	\$ 7,800			
5	\$ 9,145			
For each additional person add \$ 1,345				

#### **TO APPLY**

Submit applications and documents by email, fax or in person at either office. Upon review, additional documents may be required. Please reach out for questions or assistance in applying.

Phone: (305) 853-1788 <u>info@thegoodhealthclinic.org</u> Fax: (305) 853-1789 <u>www.thegoodhealthclinic.org</u>

**TAVERNIER:** 91555 Overseas Hwy, Suite 2, Tavernier, FL 33070 **MARATHON:** Gulfside Village Plaza, 5800 Overseas Hwy, Suite 36, Marathon, FL 33050

## **REQUIRED DOCUMENTS**

Completed Application For each household member seeking services
Photo ID  Driver License, passport, state ID, etc.  Don't have an ID? Complete application and let our staff know.
Proof of Address (Provide ONE of the following)
<ul> <li>Driver's License or state ID with address</li> <li>Deed, mortgage statement, current lease, notarized letter from landlord stating address.</li> <li>2 pieces of official mail (from bank, utility company, government agency, etc.)</li> <li>No permanent address? Complete application and let our staff know.</li> </ul>
Proof of Income (Provide <u>ALL</u> of the below for ALL adult members of your home)
<ul> <li>Current Tax Return</li> <li>Most recent month of pay stubs from all employers</li> </ul>

Documentation for social security or other government income received

NOTE: If you did not file taxes or are paid in cash, you are still welcomed and encouraged to apply. Good Health Clinic staff will assist in completing this portion of documentation.



# **PATIENT APPLICATION**

		Date:
Name:(Last)	(First)	(MI)
Date of Birth:/ S	ex: M / F Social Securi	ty #:
Phone #:	Cell #:	
Email:	<del>-</del>	
Address:	Current living arra	ingement:
City:State:Zip:	I ( □ OWN or room	I ☐ RENT ) a house, apartment,
How long have you lived here?	connected	boat which ( IS IS IS NOT) It to water and electric
I don't have a permanent address curr	rently I live/stay pay rent	with a friend or family & do NOT
How did you hear about us?		
<ul> <li>O I am an Existing/Previous patient</li> <li>O Friend/Family/Coworker</li> <li>O Internet/website</li> <li>O Newspaper Advertisement</li> </ul>	O GHC employed O Hospital: O Doctor's office O Other:	
Do you need medical care due to an accide	nt? YES NO	
Do you have a lawyer related to accident?	YES NO	
If yes, please explain.		·
Current, usual, or previous occupation:		
Current employment status:	Most recent emplo	oyers:
O Employed, Full-time O Employed, part-time or season	Employer #1:	
O Unemployed, less than 1 year O Unemployed, more than 1 year	Employer #2:	
O Retired O Student	O I am self empl	loyed
Emergency Contact:		
Name:	Relationship:	Phone #:



Primary Language?	Do you need an interpr	eter? YES NO
My regular transportation is:	my own car A borrowed car a bicycle walking	rides from friend/family Dublic transportation
MONTHLY INCOME:	MONTHLY EXPENSE	S:
Total family WAGES \$	Mortgage/Rent	\$
Other income: Rental income \$	Telephone / Interne Electric 	\$ \$ \$
Investments \$	Car Payments	\$ \$
	Auto Insurance	\$
	Credit card payment	
· · · · · · · · · · · · · · · · · · ·	Other loan payment Misc. Expenses (spe	· —————
Alimony \$	a	<u> </u>
Child Support \$ Misc. Income (specify):	b.	
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	C Total Monthly E	
Are you a Veteran? Yes No	Education:	Marital Status:
Ethnicity/Race	Did not graduation high school	Single
White	High school / GED	Married
Hispanic/Latino	Some college	Domestic Partner
African American/Black	Completed college	Separated
Asian	Completed trade school	Divorced
Other:	Master's degree or higher	Widow(er)
APPLICANT STATEMENT OF VERACITY	AND COMPREHENSION	
applicant agrees that in the event concerning this application, the application and its affiliates for the duration	sts all information and documents submit any material omission, misstatement or ant will be liable for all costs associated with this application was considered active. App and Health Clinic in the enforcement of this	misrepresentation is identified services provided by Good Health olicant will also be responsible for
Applicant Signature:		Date:
Witness Signature:		Date:



Section 1

# VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

#### **CLINIC/PROGRAM/PROVIDER: Good Health Clinic**

Does the client/patient have insurance that covers the Does anyone in the client/patient's family have an acceptance of the client of the clie						
Name of the card holder and Medicaid No						
Client/Patient/Head of Household's Name:						
(LAST NAME	) (FIRST NAI	ME) (MIDDLE INIT	TAL)			
Address:	(CITY/STATE)	(ZID CODE)				
(STREET) (CITY/STATE) (ZIP CODE)						
Telephone or Contact Number: Name of Contact:						
Section 2 Family Size: Adults Under 18	18-21Student	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 INC					
Section 3 BUDGET COMPUTATION (To be completed if far	nily income is above federal no	verty level.)				
Step 1. "TOTAL FAMILY INCOME" for family unit (Earn			\$(Above)			
Step 2. Subtract \$90 for <u>EACH</u> employed member of the famil	ну ипіт.		\$(Minus)			
		\$(Total)				
Step 3. Subtract childcare <u>PAID</u> each month (up to \$175 per c up to \$200 per child under age 2).	(3)	\$(Minus)				
		(3a)	\$(Total)			
Step 4. Subtract up to \$50 per month of total child support rec	Step 4. Subtract up to \$50 per month of total child support received.					
Step 5. TOTAL NET INCOME	Step 5. TOTAL NET INCOME					
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 VOLUNTEED OR EMPLOYEE						
(VALID FOR ONE YEAR) Expiration date:						
DH 1032E (12/14), 64I-2.002(4), F.A.C.						