Good Health Clinic

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.

2025 Patient Income Maximums

Family Size	Monthly Income
1	$ 3,912
2	$ 5,289
3	$ 6,663
4	$ 8,037
5	$ 9,414
For each additional person add $ 1,374	

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
Fax: (305) 853-1789
info@thegoodhealthclinic.org
www.thegoodhealthclinic.org

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)

- Driver's License or state ID with address
- Deed, mortgage statement, current lease, notarized letter from landlord stating address.
- 2 pieces of official mail (from bank, utility company, government agency, etc.)
- No permanent address? Complete application and let our staff know.

☐ **Proof of Income** (Provide **ALL** of the below for ALL adult members of your home)

- Current Tax Return
- Most recent month of pay stubs from all employers
- 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.

Good Health Clinic

PATIENT APPLICATION

Date: ____________

Name: ____
(Last) (First) (MI)

Date of Birth: _____/_____/________ Sex: M / F Social Security #: ______________________

Phone #: ________________________________ Cell #: ____________________________________

Email: ____

Address: ________________________________

City:__________________State:___Zip:________

How long have you lived here? _______________

☐ I don't have a permanent address currently

Current living arrangement:

☐ I (☐ OWN ☐ RENT) a house, apartment, or room

☐ I live on a boat which (☐ IS ☐ IS NOT) connected to water and electric

☐ I live/stay with a friend or family & do NOT pay rent

How did you hear about us?

- O I am an Existing/Previous patient
- O Friend/Family/Coworker
- O Internet/website
- O Newspaper Advertisement
- O GHC employee: _______________
- O Hospital: _______________
- O Doctor's office: _______________
- O Other: _______________

Do you need medical care due to an accident? ☐ YES ☐ NO

Do you have a lawyer related to accident? ☐ YES ☐ NO

If yes, please explain. ____.

Current, usual, or previous occupation: ______________________________________

Current employment status:

- O Employed, Full-time
- O Employed, part-time or season
- O Unemployed, less than 1 year
- O Unemployed, more than 1 year
- O Retired
- O Student

Most recent employers:

Employer #1: ____________________________

Employer #2: ____________________________

O I am self employed

Emergency Contact:

Name: ______________________________ **Relationship:** _______________ **Phone #:** ________________

Primary Language? ___________________________ **Do you need an interpreter?** ☐ **YES** ☐ **NO**

My regular transportation is:
☐ my own car ☐ A borrowed car ☐ rides from friend/family
☐ a bicycle ☐ walking ☐ Public transportation

MONTHLY INCOME:

Total family WAGES $________

Other income:
Rental income $________
Investments $________
Social Security (SSI or SSDI) $________
Pension/retirement funds $________
Workers' Compensation $________
Unemployment Compensation $________
Alimony $________
Child Support $________
Misc. Income (specify):
________________________ $________
________________________ $________

Total Monthly Income: $________

MONTHLY EXPENSES:

Mortgage/Rent $________
Telephone / Internet $________
Electric $________
Water $________
Car Payments $________
Auto Insurance $________
Credit card payments $________
Other loan payments $________
Misc. Expenses (specify)
a. _______________ $________
b. _______________ $________
c. _______________ $________

Total Monthly Expenses: $________

Are you a Veteran? ☐ Yes ☐ No

Ethnicity/Race
☐ White
☐ Hispanic/Latino
☐ African American/Black
☐ Asian
☐ Other: ______________

Education:
☐ Did not graduation high school
☐ High school / GED
☐ Some college
☐ Completed college
☐ Completed trade school
☐ Master's degree or higher

Marital Status:
☐ Single
☐ Married
☐ Domestic Partner
☐ Separated
☐ Divorced
☐ Widow(er)

APPLICANT STATEMENT OF VERACITY AND COMPREHENSION

By signing below, the applicant attests all information and documents submitted 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 Good Health Clinic and its affiliates for the duration this application was considered active. Applicant will also be responsible for attorney fees and costs incurred by Good Health Clinic in the enforcement of this agreement.

Applicant Signature: ____ **Date:** _______________

Witness Signature: ____ **Date:** _______________

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: Good Health Clinic

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: ______________________