



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.

2026 Patient Income Maximums

Family Size	Monthly Income
1	\$ 3,990
2	\$ 5,410
3	\$ 6,830
4	\$ 8,250
5	\$ 9,670
For each additional person add \$ 1,420	

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.



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):
_____ \$ _____
_____ \$ _____

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 Income: \$ _____

Total Monthly Expenses: \$ _____

Are you a Veteran? Yes No

Education:

Marital Status:

Ethnicity/Race

White
 Hispanic/Latino
 African American/Black
 Asian
 Other: _____

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

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: _____