Eligibility Instructions

Eligibility Process

(1) Pick up eligibility packet at Chesapeake Care Clinic or print off a copy online.
(2) Once you have filled out the packet and gathered all of your documents. Please call Chesapeake Care Clinic for pre-screening and to schedule an appointment.
(3) Please bring in packet and required documents to your eligibility appointment.
(4) Once eligible, you may schedule your initial medical and/or dental appointment.

Things to Remember

- **Please read the entire packet carefully and have filled out prior to your eligibility appointment**
- **If scheduling a dental appointment you will need an additional $30**
- **The term "household" used in this packet refers to anyone who is claimed or claims you on taxes, dependent(s), and/ or spouse.**

Household size	1	2	3	4	5	6	7	8	For each additional member add
Maximum Annual Income	38,280	51,720	65,160	78,600	92,040	105,480	118,920	132,360	16,800

The following figures are taken from the 2019 HHS Poverty Guidelines published in the Federal Register on February 1, 2019.
Source: https://aspe.hhs.gov/poverty-guidelines

Eligibility Requirements for Medical Services

(1) Must be a resident of one of the 7 cities in the Hampton Roads area.
(2) Cannot have any insurance at all. No medical, dental, or vision insurance, plans, or coverage of any kind.
(3) Must meet the income guidelines. Cannot exceed 300% of the federal poverty level based on the number of people in your household.

Eligibility Requirements for Dental Services

(1) Must be a resident of one of the 7 cities in the Hampton Roads area.
(2) Cannot have any dental insurance, plan, or coverage at all.
(3) We do accept patients who have Medicare as long as they don't have any dental coverage with a supplemental plan.
(4) We do accept Medicaid patients if their Medicaid is through the Managed Care Organization (MCO) United Health Care. Unfortunately, if you have any other MCO, you are not eligible because your MCO has a dental benefit.
(5) Must meet the income guidelines. Cannot exceed 300% of the federal poverty level based on the number of people in your household.

Chesapeake Care
2145 S. Military Highway
Chesapeake, VA 23320
(757) 545-5700

Eligibility Checklist

Name: ___________________________________

To be prescreen and schedule an eligibility appointment, please call 545-5700 ext 5001

You will need to bring the items listed below to your eligibility appointment. Digital documentation is not accepted. You will be rescheduled if you fail to bring required documents.

(1) Photo ID
(2) Social Security Card
(3) Proof of address (utility, cell phone, medical bill, lease, or mortgage statement)- **WITHIN THE LAST 90 DAYS**
(4) Federal Tax Return **with all forms and schedules attached** – if you file or someone else claims you
(5) Insurance Card – if applicable
(6) Proof of income **(please fill out chart below to determine documents needed)**

Question	Answer	Documents needed
Is any member of your household** **self-employed**?	❑YES ❑NO	COMPLETE TAX form(s) including business taxes from the most recent tax year and latest quarterly filing listing income for quarter **AND** **90 days** of: Business bank statements, receipts, invoices, and profit/loss statements.
Is any member of your household** **employed**?	❑YES ❑NO	**60-day period** of recent pay stubs or signed letter from employer on company letterhead with rate of pay and number of hours worked weekly.
Is any member of your household** receiving **Social Security or Supplemental Security Income**?	❑YES ❑NO	SS benefit award letter – You can contact Social Security at 1-800-772-1213 or visit your local Social Security Office to obtain copy of award letter
Does any member of your household** receive **Veterans Benefits**?	❑YES ❑NO	Benefit statement for current year
Are you a **Veteran but not eligible** for **medical benefits** from the VA?	❑YES ❑NO	Letter from the VA stating you are not eligible for Medical Benefits
Does any member of your household** receive a **Pension or Retirement**?	❑YES ❑NO	Pension/Retirement Award letter or statement
Does any member of your household** receive **Unemployment?**	❑YES ❑NO	Unemployment award letter indicating amount and time period covered or **90 days** of most recent unemployment checks.
Does any member of your household** receive **Alimony or Child Support?**	❑YES ❑NO	Court award letter indicating amount and time period covered, Child Support Enforcement Agency letter, letter from attorney stating amount and time period covered, or **90 days** of monthly checks.
Does any member of your household** receive **Workers Compensation**	❑YES ❑NO	Letter or benefits statement indicating amount and time period covered or **90 days** of check stubs.
Does any member of your household** receive **SNAP benefits?**	❑YES ❑NO	SNAP Letter
Does any member of your household** receive a **TANF or TANF Transitional assistance** ?	❑YES ❑NO	TANF Letter or TANF transitional letter
Does any member of your household** receive **housing and /or utility assistance**?	❑YES ❑NO	Housing Assistance Letter
Does any member of your household** own **rental or investment property**?	❑YES ❑NO	Rental agreement/documentation listing income amount.
Does any member of your household** have **other sources of income**?	❑YES ❑NO	Stocks, Bonds, CDs, 401K, additional property, etc. Attach **90 days** of most recent statements.
Does any member of your household** have a **checking, savings or money market account** ?	❑YES ❑NO	Attach complete copy of current **90 days** of statements for each account owned.
Are you claiming **no income**? (If claiming no income and do not already receive SNAP benefits, you must apply and bring in letter stating approval and the amount getting monthly or a denial letter)	❑YES ❑NO	Verification of support form completed by person providing your food, shelter and daily living expenses (form attached to back of this packet) **and** SNAP Letter.

**** Household- anyone who is claimed or claims you on taxes, depend(s), and/ or spouse.**

Please note, you will need $30 cash if you plan to schedule a dental appointment after completing eligibility

Date______________________________
Interviewer______________________
Eligibility valid until_______________
Chart Number____________________

Chesapeake Care
Patient Information Sheet

Please Print

Last Name_______________________ First Name_____________________ Middle_____________ Suffix_____

Sex _____________ Date of Birth ______________________ Social Security # ___________________________

Address ____Apt/ Lot #________________________

City _________________________ State _________________________ Zip _____________________________

Home phone # _____________________ Cell phone # ______________________ Consent to text ☐ Yes ☐ No

Work phone # ________________ E-mail address ____

Best phone # and time to contact you ______________________________

Primary language spoken ______________________ Race ________________ Hispanic/Latino ☐Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact:

Name ____________________________ Relationship _______________ Phone # _________________________

How did you learn about our clinic? ____

Are you a U.S. citizen? ☐ Yes ☐ No

Employment Status ☐Unemployed ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Student

Employer's name, phone#, and address ____

Do you have any heath insurance, Medicare, or Medicaid?	Yes	No
Insurance Name ______________________________		
Policy Holder Name___________________________		
Policy or member number______________________		
Do you have dental insurance?	Yes	No
Insurance Name ______________________________		
Policy Holder Name___________________________		
Policy or member number______________________		
Do you have a vision plan?	Yes	No
Are you a Veteran?	Yes	No
Do you receive disability?	Yes	No
If yes, what kind and when did it start? __________________________		
Did you file a tax return for 2019?	Yes	No
If no, why not? ____		
Does someone claim you as a dependent?	Yes	No
If yes, who claims you? ______________________________________		

Office Staff Only
Initial Appt. Date __________________
Please Circle MED DEN
Registration completed by___________

Revised 02/2020

Chesapeake Care - Health History

Name: ____________________________________ DOB: _________________ Date: __________________

Do you or an immediate family member have any of the following health conditions?

	You		Family Member	
	Yes	No	Yes	No
Addiction				
Anemia				
Arthritis/Gout				
Asthma				
Bleeding Disorder				
Blood Clots				
Cancer				
Congestive Heart Failure				
Depression / Anxiety				
Diabetes				
COPD/Emphysema				
Epilepsy/Seizures				
GI Disorder				
Glaucoma				
Heart attack/disease				
Heart Murmur				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Sickle Cell Anemia				
Skin Disease				
Stroke				
Thyroid Disease				
Ulcer				
Fractures				
Other				

Date of last Seasonal Flu Shot __________
Date of Pneumonia Vaccine? _______
Date of last Tetanus shot? _____________
Any reactions to vaccines? ____________
Date of last dental exam? _____________

Do you smoke? ______________
If so, how many packs/day? __________
When stopped? ______________
Do you use smokeless tobacco? ________
If so, how often? _____________
When stopped? ___________
Do you drink alcohol? __________
When stopped? ___________________

Drug Allergy: **Reaction:**

______________ _________________
______________ _________________
______________ ________________

Women's Health
Number of Pregnancies? __________
Number of Children? __________
Last Pap Smear? __________
Last Mammogram? __________
Previous Abnornal Pap Smear? ________
Hormone Replacement Therapy? ________
Current Birth Control ______________

Previous Primary Care Provider: ____

List Medications (include over the counter)		
Name of Medicine	Dose	How Often
1		
2		
3		
4		
5		
6		
7		
8		

Surgeries

Date, Surgery, and Where

1 ____________________________________
2 ____________________________________
3 ____________________________________

ER Visits or Hospitalizations

Date and Where

1 ____________________________________
2 ____________________________________
3 ____________________________________

Chesapeake Care Clinic
Fee Disclosure

Chesapeake Care Clinic is committed to providing excellence in patient care. We are an independent charity clinic (not part of the city, state or hospital systems of care). In order for us to meet our financial obligations, it is necessary for us to collect fees for the administrative and material process that takes place with each and every visit. Your exceptional care is being provided primarily by generous volunteers that are not receiving compensation. However, the cost of supportive services continues to rise as do the costs of maintaining our facility. The nominal fees below will help us to continue to serve your medical and dental needs and represent a 90% discount for the true cost of providing that care. The reality is that without these *nominal* fees, we will not be here to help any of our patients or future patients in the years to come.

Fee Schedule - All Fees Are Non-Refundable

Dental Materials Fee- $30 cash- every appointment *(effective August 2015)*
This fee is a prepay fee. In order to receive an appointment it is necessary to pay the materials fee first. If you no-show for a dental appointment, the $30 materials fee will not be refunded. You will be required to prepay $30 to reschedule.

Medical Administration Fee- $10 cash- every appointment *(effective April 2013)*
This fee is collected at the time of your appointment for all medical and specialty visits. *There is no admin fee for counseling, blood pressure checks and diabetic nurse education visits.*

Medication Processing Fee- cash only *(effective February 2011)*
This fee is a processing fee. It is not a charge for the medications.
$2- 30-day supply
$4- 60-day supply
$5- 90-day supply
$5- Glucose meter
$5- Glucose test strips (box of 50)
$5- Colonoscopy prep
$2- Lancets/box
$2- Insulin syringes (quantity 30)

Miscellaneous – cash only (*effective April 2013)*
This is a processing fee and should be prepaid.
Completion of Forms by Physician - $5/form
Medical Records - $0.50/page with $10 administration fee

All fees are non-refundable.
By signing you are acknowledging you have been informed of our charges.

____
Printed Name

____ ______________________
Patient's Signature Date of Birth

____ ______________________
Witness Date

Chesapeake Care
2145 S. Military Highway
Chesapeake, VA 23320
(757) 545-5700
(757) 545-7706 fax

CHESAPEAKE CARE CLINIC
VERIFICATION OF SUPPORT

PATIENT NAME: ____

DATE: _______________ DOB:_____________________

The following verification of support must be completed and returned to the clinic upon request, or during eligibility.

I, ____, am providing food

and shelter for ____

in the amount estimated at $_______________________________ each month.

I claim this person on my Federal Income taxes. (Circle one – YES* / NO)
* If yes, please furnish your tax form and all supporting income documentation.

I realize that someone may contact me to verify this information.

**Disclaimer: I attest that this information provided is genuine and accurate. I understand that giving false information may result in the patient named above losing privileges to receive services from Chesapeake Care Free Clinic.

Signature ____

Print Name ____

Address ____

____

Date: ____

Revised May2014