Eligibility Instructions

Eligibility Process

Paper Application

(1) Once you have filled out the packet and gathered all of your documents, please call Chesapeake Care Clinic to schedule an eligibility appointment.

(2) Please bring in packet and required documents to your eligibility

Online Application

(1) Complete the application and upload supporting documents www.chesapeakecare.org.

(2) Once we have received and reviewed your online application, we will contact you via email or telephone to complete the eligibility process. -Incomplete Applications will only be held for 30 days

Once eligible, you may schedule your initial medical and/or dental appointment(s).

Things to Remember

- **Please read and complete the entire packet carefully prior to your eligibility appointment.**
- **If scheduling a dental appointment, you will need to be prepared to pay $30.00 to schedule. We accept credit/debit cards and cash only.**
- **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	47,880	64,920	81,960	99,000	116,040	133,080	150,120	167,160	17,040

The following figures are taken from the 2026 HHS Poverty Guidelines published in the Federal Register on February 1, 2026.
Source: https://aspe.hhs.gov/poverty-guidelines

Eligibility Requirements for Medical Services

(1) Must live in the City of Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, or Virginia Beach.
(2) Uninsured. 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 live in the City of Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, or Virginia Beach.
(2) Uninsured. We accept patients who have Medicare as long as they don't have any dental coverage with a supplemental plan. We do NOT accept Medicaid patients.
(3) Must meet the income guidelines. Cannot exceed 300% of the federal poverty level based on the number of people in your household.

Eligibility Checklist

To schedule an eligibility appointment, please call 545-5700 ext 501

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/Taxpayer Identification Number – if applicable
(3) Proof of address (utility, cell phone, medical bill, lease, or mortgage statement)- **WITHIN THE LAST 90 DAYS**
(4) Federal Tax Return (most recent) **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)**

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 verification 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 Notice of Action of benefits letter
Does any member of your household** receive 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**?	❑YES ❑NO	Verification of support form completed by person providing your food, shelter and daily living expenses **and** notarized certification form (forms attached to back of this packet). We have notary public and can notarize form.

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

Chesapeake Care
Patient Information Sheet

Date_____
Interviewer_____
Eligibility valid until_____
Chart Number_____

Please Print

Last Name_____ First Name_____ Middle_____ Suffix_____

Sex _____ Date of Birth _____ Social Security/TIN # _____

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

Type of Employment ☐Lawn/landscaping ☐Construction/skilled trade ☐Housekeeping/cleaning
☐Food Service/restaurant ☐Childcare ☐Retail ☐Healthcare ☐Other:_____

Employer's name, phone#, and address _____

In the 12 months before today, how many times have you visited the emergency room? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

Do you have any heath insurance, Medicare, or Medicaid? Yes No
Insurance Name _____
Do you have dental insurance? Yes No

Do you have a vision plan? Yes No

What type of insurance did you lose?
☐Medicaid ☐ ACA marketplace ☐Employer-sponsored insurance ☐other:_____

Why did you lose Medicaid Coverage?
☐Increased Income ☐Work requirements ☐ non-citizen ☐ Incomplete paperwork

Have you ever served in the US military? Yes No

Do you receive disability? Yes No
If yes, what kind and when did it start? _____
Did you file a tax return for 2025? Yes No
If no, why not? _____
Does someone claim you as a dependent? Yes No
If yes, who claims you? _____

Office Staff Only

New____ Renewal____ Initial Appt. Date _____

Please Circle MED DEN

Registration completed by_____ _____

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 Abnormal 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 excellent 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. You may make fee payments online at our website www.chesapeakecare.org or pay in office with credit/debit card, cash, or money order.

Fee Schedule - All Fees Are Non-Refundable

Dental Materials Fee- $30 - 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. The $30 materials fee will not be refunded if you no-show for a dental appointment. You will be required to prepay $30 to reschedule.

Medical Administration Fee- $10 - 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, or diabetic nurse education visits*.

Medication Processing Fee- *(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 – **(***effective April 2013)*
Completion of Forms by Physician - $5/form- This processing fee should be prepaid.
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

Revised 04/2021

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 Clinic.

Signature _____

Print Name _____

Address _____

_____

Date: _____

Chesapeake Care Clinic

Unemployment Certification Form

I, _____ (patient name), hereby certify that:

☐ I am currently unemployed. I do not receive wages, salary, or self-employment income. I have been unemployed since _____.

☐ I am unhoused.

☐ I am a full-time student.

☐ I do not have a bank account

☐ I did not file taxes in 2025

to be signed in front of notary public

Patient Attestation

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that providing false or misleading information may affect my eligibility for services and may result in denial of assistance.

Signature _____ DOB: _____

VIRGINIA NOTARY ACKNOWLEDGEMENT

COMMONWEALTH OF VIRGINIA

CITY/COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of

_____, 20___, by _____.

_____
Signature of Notary Public

Notary Registration Number: _____

My Commission Expires: _____