



## Eau Claire Cooperative Health Centers, Inc. Good Samaritan Plan (GSP)

The Eau Claire Cooperative offers financial assistance to qualified patients and their household members for visits to any of its office locations. The Cooperative also provides discounted assistance for prescriptions and Labs. **All Laboratory fees are to be paid prior to labs being drawn based on GSP Level. All GSP patients must present proper identification at each visit.**

**Financial assistance can start today!**

*To see if you qualify, review the following information...*

### Qualifying is easy as 123 or ABCD

Find your household size and monthly income on the chart.

Step 1. Circle Household Size

Step 2. Circle Monthly Gross Income Range (on same line) for household size you selected.  
Household income must be within the range to qualify.

Step 3. Circle Category A, B, C, or D that fits your income range

#### CHART – Find your Financial Level

Household Size	Income @ or less than	Monthly Gross Income Ranges		Income @ or more than
		A - \$20.00	B - \$35.00	
1	1218	1219-1498	1499-1805	1806
2	1639	1640-2016	2017-2428	2429
3	2060	2061-2533	2534-3052	3053
4	2481	2482-3050	3051-3675	3676
5	2901	2902-3568	3569-4298	4299
6	3322	3323-4085	4086-4922	4923
7	3743	3744-4602	4603-5545	5546
8	4164	4165-5120	5121-6168	6169

*Income at or above Level D pays 100% of regular charges.*

If you circled A – B – C – D

*This is what you pay for the following services:*

#### CHART #2 – Your Financial Category Level

Financial Category Level	Office visit	MD during Hospital stay (per day)	Procedures (per \$100)	Lab Services within Formulary (Per test)
A	\$20.00	\$20.00	\$20.00	Discounted Fee
B	\$35.00	\$35.00	\$35.00	Discounted Fee
C	\$45.00	\$45.00	\$45.00	Discounted Fee
D	100%	100%	100%	Discounted Fee

*Example:*

Step 1. If your household size is 4 (Circle 4)

Step 2. If your monthly gross income is \$2490 (Circle the range 2482-3050)

Step 3. Your income range would be in category B, so (Circle B)

All your fees will be marked on the B line of CHART #2

For more information about the Good Samaritan Plan, contact:

GSP Coordinator at (803) 733-5969 Extension 4129 or 4168

To sign up for the GSP, we need to know the following..... Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (The date the application is turned in)

## Family Information

Applicant's Name \_\_\_\_\_ SS# \_\_\_\_\_

(must be 18 yrs or older)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Please list all household members (include yourself on the first line)

Family Member	Name(s)	DOB MM/DD/YYYY	Social Security Number	Student (S)	Employed (E)	Other (O)	Office Use Only
1 (self)		/ /					
2		/ /					
3		/ /					
4		/ /					
5		/ /					
6		/ /					
7		/ /					
8		/ /					
9		/ /					
10		/ /					

For financial assistance to continue beyond today, income documentation and picture ID is required. Patients that have Commercial Insurance Coverage are not eligible to apply for GSP

<p><b><u>Income Documentation</u></b>  <i>Only one of the following and current ID is needed!                  Bring one in before your next visit.</i></p> <p>1. One month's worth of check stubs (within 30 days of app)                  Date: _____ Weekly \$ _____                  Or Every (2) weeks \$ _____                  Or Monthly \$ _____</p> <p>2. Current Unemployment Statement of Benefits                  (accepted only if benefits are actually being paid)</p> <p>3. IRS Form 1040 and W-2 for year 2009</p> <p>4. Letter from Employer stating salary/wages                  (Letter must indicate Tax ID# of employer and phone#)</p> <p>5. Social Security/Disability Check Stub or Statement</p> <p>6. Public Assistance Award Letter</p> <p>7. Other Proof of Income (based on approval of Billing Mgr)</p> <p><b>Current ID</b></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p>	<p>In compliance with Federal laws, I certify that the information submitted is true. Information should be updated every year or upon request.</p> <hr/> <p><b>Applicant's Signature</b> _____ <b>Date</b> _____</p> <p><i>Patients who do not provide all required documentation will be considered <u>Self-Pay</u> and will be required to pay full charges at the next visit.</i></p> <p style="text-align: center;"><b>Office Use Only</b></p> <p>Approved _____ Level _____ Date _____                  Disapproved _____ Reason _____</p> <p>PSR/PSTL Signature _____</p> <hr/> <p>Weekly _____ Monthly _____ Yearly _____</p>
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