Cooperative Health

2026

Good Samaritan Plan (GSP) Sliding Fee Application

___ First Time Applicant

___ Renewal ___ Additional Documentation attached

Location:_____

Today's date: _____/____/2025

Before Final GSP Approval can be given the following must be received at time of application or within 14 days of application.

1. Current Photo ID along with One Proof of Income for applicant and other household members age 18 and older.
2. Proof of Identity for all Household dependents listed under age of 19

Proof of Income

- All Proof of Income Must be current within 30 days of application
- If Paid in Cash, Self Employed or Do Not have any source of income **(Complete Declaration of Income Form)**

Note: Total Gross Income will be Calculated to determine approval

****See List of Acceptable Documentation****

Applicant's Name_____

___ (Must be 18 yrs. or older)

Email:_____

Address_____

City_____

State_____ **Zip**_____

Home Phone_____

Phone 2: _____ □ work □ cell

List yourself on line #1, spouse or significant other on line #2 and all dependents under the age of 19 on lines 3-7.

Household Member	Name(s)	DOB MM/DD/YYYY	Student (S)	Other (O)	Office Use Only Patient/Chart #
1 (self)		/ /			
2		/ /			
	Dependents under age 19				
3		/ /			
4		/ /			
5		/ /			
6		/ /			
7		/ /			

I certify that the information submitted is true. By signing below I understand and agree to comply with the following.

1. I understand and agree that I am responsible for notifying Eau Claire Cooperative Health Centers, Inc. of any changes in my household size or income by completing a new application.
2. I understand that my GSP Approval is good for one year from the date of approval with all required documents.
3. I understand that I am responsible for paying my office visit co-pay at the time of service along with any other charges that I may incur during my visit. I.e. Labs, Procedures and Vaccines.
4. I understand that if I do not provide all required documentation within 14 days of this application, I will not be approved for a Sliding Fee Discount and I will be responsible for all charges incurred at my next visit.

X _____ _____

Applicant Signature **Date**

▼▼**BELOW SECTION FOR OFFICE USE ONLY****▼▼**

Application Received by: _____ **Date:**_____

Reviewed by: _____ ☐Mgr. ☐PSR **Date:** _____

Reviewed by: _____ ☐Mgr. ☐PSR **Date:** _____

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Final GSP Approval Level: _____Date: _____ GSP Staff Signature:_____