SpectraPlan Application

RESPONSIBLE PARTY: ______________________________ DATE OF BIRTH: ____________
(LAST NAME) (FIRST NAME) (M.I.)

BILLING ADDRESS: ______________________________
(CITY) (STATE) (ZIP CODE)

HOME PHONE: ______________________________ SOCIAL SECURITY #: ____________

EMAIL ADDRESS: ______________________________

☐ **I AM REFUSING TO PARTICIPATE IN THE DISCOUNT PROGRAM. I understand that I can reapply at any time if needed. Please explain why you are refusing to participate:** ______________________________

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SIGNATURE: (only if refusing to participate): ______________________________ **DATE:** ____________

Please circle the gross yearly income range for your family size in the chart below:

	GREEN SLIDE - 100%		BLUE SLIDE - 75%		GRAY SLIDE - 50%		WHITE SLIDE - 25%	
FPL%	**0% - 100%**		**101% - 133%**		**134% - 167%**		**168% - 200%**	
SIZE	From	To	From	To	From	To	From	To
1	**0**	$12,490	$12,491	$16,612	$16,613	$20,858	$20,859	$24,980
2	**0**	$16,910	$16,911	$22,490	$22,491	$28,240	$28,241	$33,820
3	**0**	$21,330	$21,331	$28,369	$28,370	$35,621	$35,622	$42,660
4	**0**	$25,750	$25,751	$34,248	$34,249	$43,003	$43,004	$51,500
5	**0**	$30,170	$30,171	$40,126	$40,127	$50,384	$50,385	$60,340
6	**0**	$34,590	$34,591	$46,005	$46,006	$57,765	$57,766	$69,180
7	**0**	$39,010	$39,011	$51,883	$51,884	$65,147	$65,148	$78,020
8	**0**	$43,430	$43,431	$57,762	$57,763	$72,528	$72,529	$86,860
9	**0**	$47,850	$47,851	$63,641	$63,642	$79,910	$79,911	$95,700
10	**0**	$52,270	$52,271	$69,519	$69,520	$87,291	$87,292	$104,540

Please indicate which type of income your household receives AND provide proof of all household income within 30 days from the date on this application.

SOURCES OF INCOME	HOUSEHOLD RECEIVES	ACCEPTED DOCUMENTATION
WAGES/ Income received from employment	YES/NO	Last Federal Income tax return, last two paystubs prior to the signature date on this application OR letter from employer stating average hours/ wages paid for new employment
Immigration income	YES/NO	Immigration forms I20 or J1 document
Self-Employment	YES/NO	Ledger or income and expenses for the current or prior year taxes
Public Assistance –TANF/MFIP	YES/NO	Award Letter(s) listing amount received in the current year
SSDI	YES/NO	Award Letter(s) listing amount received in the current year
Social Security Benefits	YES/NO	Award Letter(s) listing amount received in the current year
Unemployment/Workers' Compensation	YES/NO	Benefit Award Letter for the current year
Retirement/Pension	YES/NO	Letter supplied by system administrator with monthly benefit amount for the current year
No Income at this time	YES/NO	Letter from previous employer with last day of employment, letter from case worker stating lack of income or Tax form 4506T

Please complete table for yourself and all other individuals in the household regardless of insurance status:
NOTE: (DO NOT list individuals for which the responsible party is not FINANCIALLY responsible)

LAST NAME, FIRST NAME	DATE OF BIRTH	RELATIONSHIP	RECEIVES INCOME	INSURANCE CARRIER MEDICAID, MEDICARE, BCBS, CHIP, ETC.
		Self	YES/NO	
			YES/NO	
			YES/NO	
			YES/NO	
			YES/NO	
			YES/NO	

Please read carefully before signing:

I understand that there will be a nominal fee of $30 (Dental Clinic) or $20 (Medical Clinic) or $3 (Specialty Behavior Health) due at the time of **EACH** visit. I also understand that any labs processed at Spectra Health will qualify for the SpectraPlan, **BUT** any lab work that is sent to an outside lab for processing will be my financial responsibility.

X____ ______________________

APPLICANT SIGNATURE DATE

Proof of Income:

Proof of income is required. By signing below, I agree that Spectra Health staff may contact each employer and/or may contact other agencies to confirm the income listed. **Within 30 days**, I will give Spectra Health a copy of all information requested, for all people in the home to see if I qualify for discounts. If I do not provide this within the 30 days I will be responsible for the full amount of the visit. I will be asked to reapply for the program annually and I will update my application within 30 days if my household size, income, or insurance changes. If I do not provide correct information, I may not be eligible for the SpectraPlan.

Applicants who currently receive NO INCOME must provide appropriate documentation of the lack of income. (See accepted documentation table on the first page for examples.)

X____ ______________________

APPLICANT SIGNATURE DATE

FOR SPECTRA HEALTH USE ONLY

Total Annual Income: $ ______________________________ Sliding Fee Scale Discount: ______________________

Applied: ____________________ SP Appt: ____________________ SP Verified: ____________________

Spectra Health Representative Signature: ______________________________ Date: ____________________

Supplemental Rate Guide

DENTAL SERVICES ON THE FIXED RATE DISCOUNT PLAN

Partial Maxillary Denture $900
$450 due at scheduling; balance due at appointment

Partial Mandibular Denture $900
$450 due at scheduling; balance due at appointment

Interim PD (Flipper, 1-2 teeth) Partial $500
$250 due at scheduling; balance due at appointment

Any Crown $900
$450 due at scheduling; balance due at appointment

Primary Stainless Steel Crown .... $200 due at scheduling
Permanent Stainless Steel Crown .... $250 due at scheduling
Night Guards .... $250 due at scheduling
Internal Bleaching .... $250 due at scheduling

MEDICAL SERVICES ON THE FIXED RATE DISCOUNT PLAN

Flu Vaccine & Administration .... $30 due at appointment
Vivitrol (Per Dose) .... $1140 due at appointment
Shingrix Vaccine (Per Dose) (age 50 and older) .... $150 due at appointment
Zoster Vaccine (Per Dose) (age 50 and older) .... $200 due at appointment
Varicella Vaccine (Per Dose) (age 19 and older) .... $95 due at appointment

MEDICAL SERVICES NOT COVERED BY SPECTRAPLAN

DOT Physical .... $110 due at appointment
Sports Physical .... $30 due at appointment
Camp Physical .... $30 due at appointment

WOMEN'S HEALTH SERVICES NOT COVERED BY SPECTRAPLAN

IUD device $150
IUD insertion $175
IUD removal $175
Nexplanon device $500
Nexplanon insertion $175
Nexplanon removal $175

- *Women's Health: Estimated 50% due at appointment – Balance due at billing.*
- *Pricing above is specific to each device/procedure. Additional charges may be incurred during a visit based upon medical necessity.*