SpectraPlan Application

Spectra HEALTH | Redefining Care

Date: _____

Patient Label

Responsible Party: _____
Last Name First Name M.I.

Date of Birth: _____

Please indicate which type of income your household receives AND provide proof of all household income within 30 days of application.

SOURCES OF INCOME	HOUSEHOLD RECEIVES	ACCEPTED DOCUMENTATION
Employment Income	YES / NO	• Most recent Federal Income tax return • Last (2) paystubs • Letter from employer validating hours/wages
Immigration Income	YES / NO	• Immigration forms I20 or J1
Self-Employment	YES / NO	• Current Income Statement • Prior year income tax return
Public Assistance –TANF/MFIP	YES / NO	• Award Letter(s) listing amount received (current year)
SSDI	YES / NO	• Award Letter(s) listing amount received (current year)
Social Security Benefits	YES / NO	• Award Letter(s) listing amount received (current year)
Unemployment Compensation	YES / NO	• Benefit Award Letter (current year)
Workers' Compensation	YES / NO	• Benefit Award Letter (current year)
Retirement/Pension	YES / NO	• Plan administrator documentation stating monthly benefit amount (current year)
No Income	YES / NO	• Letter from previous employer documenting last day of employment • Letter from Case worker (agency letterhead required) • Tax Form 4506t

	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE FOR DISCOUNT PROGRAM
	GREEN - 100%	BLUE - 75%	GRAY - 50%	WHITE - 25%	
FPL%	0% - 100%	>100% - 133%	>133% - 167%	>167% - 200%	> 200%
SIZE	**INCOME**	**INCOME**	**INCOME**	**INCOME**	**INCOME**
1	$0 - $12,880	$12,881 - $17,130	$17,131 - $21,510	$21,511 - $25,760	$25,761 & Above
2	$0 - $17,420	$17,421 - $23,169	$23,170 - $29,091	$29,092 - $34,840	$34,841 & Above
3	$0 -$21,960	$21,961 - $29,207	$29,208 - $36,673	$36,674 - $43,920	$43,921 & Above
4	$0 -$26,500	$26,501 - $35,245	$35,246 - $44,255	$44,256 - $53,000	$53,001 & Above
5	$0 -$31,040	$31,041 - $41,283	$41,284 - $51,837	$51,838 - $62,080	$62,081 & Above
6	$0 -$35,580	$35,581 - $47,321	$47,322 - $59,419	$59,420 - $71,160	$71,161 & Above
7	$0 -$40,120	$40,121 - $53,360	$53,361 - $67,000	$67,001 - $80,240	$80,241 & Above
8	$0 -$44,660	$44,661 - $59,398	$59,399 - $74,582	$74,583 - $89,320	$89,321 & Above
9	$0 -$49,200	$49,201 - $65,436	$65,437 - $82,164	$82,165 - $98,400	$98,401 & Above
10	$0 -$53,740	$53,741 - $71,474	$71,475 - $89,746	$89,747 - $107,480	$107,481 & Above

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Complete table for applicant and **all** other individuals within 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	Income Source	Receives Income	How often income is received?	Insurance: Medicaid, Medicare, BCBS, CHIP, etc
		Self		Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		

Total Family Size: #_____ Total Income: $_____

PLEASE READ CAREFULLY AND INITIAL BEFORE SIGNING

_____ Initials I understand that there is a nominal fee of $30 (Dental), $20 (Medical), or $3 (Specialty Behavioral Health) that is due at the time of EACH visit. Additionally, I understand that any labs processed at Spectra Health will qualify for the SpectraPlan Discount; however, any lab work that is sent to an outside lab will be my personal financial responsibility.

_____ Initials Proof of income is required. **Within 30 days**, I agree to provide Spectra Health with all mandatory information, for all requested individuals, to determine discount qualification. **Failure to provide requested documentation (within 30 days) may prevent any eligible discount.**

Applicants who do NOT receive income must provide approved documentation (see accepted documentation table (page1) for examples).

By signing below, I agree that Spectra Health staff may contact each employer of all individuals working within the household and/or authorized agencies to confirm provided income. I will be asked to reapply for the SpectraPlan program annually. Any changes to household size, income, or insurance status requires notification to Spectra Health within 30 days. Failure to provide updated information may result in termination of SpectraPlan eligibility.

X_____ _____

Applicant Signature Date

SpectraPlan
Supplemental Rate Guide

Spectra HEALTH | Redefining Care

FIXED SPECTRAPLAN DISCOUNT DENTAL SERVICES

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

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

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

Any Crown $780
$390 due at scheduling; balance due appointment

Addition to Partial Denture (Per Tooth) (Max of 2) ..... $200 due at scheduling

Permanent Stainless Steel Crown ..... $250 due at scheduling

Pulpal Debridement ..... $50 due at scheduling

Root Canal ..... $50 due at scheduling

Night Guards ..... $250 due at scheduling

Internal Bleaching ..... $250 due at scheduling

FIXED SPECTRAPLAN DISCOUNT MEDICAL SERVICES

Sublocade (Per Dose) ..... $1500 due at scheduling

Vivitrol (Per Dose) ..... $1000 due at scheduling

Flu Vaccine & Administration ..... $30 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 apointment

SERVICES NOT COVERED BY THE SPECTRAPLAN

DOT Physical ..... $110 due at appointment

Sports Physical ..... $30 due at appointment

Camp Physical ..... $30 due at appointment

Substance Use Assessment ..... $145 due at appointment

*** Pricing is specific to each device/procedure. Additional charges may be incurred during a visit based upon medical necessity.**