

# SpectraPlan Application



Redefining Care

Date: \_\_\_\_\_

Responsible Party: \_\_\_\_\_  
Last Name First Name M.I.

Billing Address: \_\_\_\_\_  
City State Zip Code

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ 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
<b>Employment Income</b>	YES / NO	<ul style="list-style-type: none"> <li>Most recent Federal Income tax return</li> <li>Last (2) paystubs</li> <li>Letter from employer validating hours/wages</li> </ul>
<b>Immigration Income</b>	YES / NO	<ul style="list-style-type: none"> <li>Immigration forms I20 or J1</li> </ul>
<b>Self-Employment</b>	YES / NO	<ul style="list-style-type: none"> <li>Current Income Statement</li> <li>Prior year income tax return</li> </ul>
<b>Public Assistance – TANF/MFIP</b>	YES / NO	<ul style="list-style-type: none"> <li>Award Letter(s) listing amount received (current year)</li> </ul>
<b>SSDI</b>	YES / NO	<ul style="list-style-type: none"> <li>Award Letter(s) listing amount received (current year)</li> </ul>
<b>Social Security Benefits</b>	YES / NO	<ul style="list-style-type: none"> <li>Award Letter(s) listing amount received (current year)</li> </ul>
<b>Unemployment Compensation</b>	YES / NO	<ul style="list-style-type: none"> <li>Benefit Award Letter (current year)</li> </ul>
<b>Workers’ Compensation</b>	YES / NO	<ul style="list-style-type: none"> <li>Benefit Award Letter (current year)</li> </ul>
<b>Retirement/Pension</b>	YES / NO	<ul style="list-style-type: none"> <li>Plan administrator documentation stating monthly benefit amount (current year)</li> </ul>
<b>No Income</b>	YES / NO	<ul style="list-style-type: none"> <li>Letter from previous employer documenting last day of employment</li> <li>Letter from Case worker (agency letterhead required)</li> <li>Tax Form 4506t</li> </ul>

	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE FOR DISCOUNT PROGRAM
	GREEN - 100%	BLUE - 75%	GRAY - 50%	WHITE - 25%	
<b>FPL%</b>	0% - 100%	>100% - 133%	>133% - 167%	>167% - 200%	> 200%
<b>SIZE</b>	<b>INCOME</b>	<b>INCOME</b>	<b>INCOME</b>	<b>INCOME</b>	<b>INCOME</b>
<b>1</b>	\$0 - \$13,590	\$13,591 - \$18,075	\$18,076 - \$22,695	\$22,696 - \$27,180	\$27,181 & Above
<b>2</b>	\$0 - \$18,310	\$18,311 - \$24,352	\$24,353 - \$30,578	\$30,579 - \$36,620	\$36,621 & Above
<b>3</b>	\$0 - \$23,030	\$23,031 - \$30,630	\$30,631 - \$38,460	\$38,461 - \$46,060	\$46,061 & Above
<b>4</b>	\$0 - \$27,750	\$27,751 - \$36,908	\$36,909 - \$46,343	\$46,344 - \$55,500	\$55,501 & Above
<b>5</b>	\$0 - \$32,470	\$32,471 - \$43,185	\$43,186 - \$54,225	\$54,226 - \$64,940	\$64,941 & Above
<b>6</b>	\$0 - \$37,190	\$37,191 - \$49,463	\$49,464 - \$62,107	\$62,108 - \$74,380	\$74,381 & Above
<b>7</b>	\$0 - \$41,910	\$41,911 - \$55,740	\$55,741 - \$69,990	\$69,991 - \$83,820	\$83,821 & Above
<b>8</b>	\$0 - \$46,630	\$46,631 - \$62,018	\$62,019 - \$77,872	\$77,873 - \$93,260	\$93,261 & Above
<b>9</b>	\$0 - \$51,350	\$51,351 - \$68,296	\$68,297 - \$85,755	\$85,756 - \$102,700	\$102,701 & Above
<b>10</b>	\$0 - \$56,070	\$56,071 - \$74,573	\$74,574 - \$93,637	\$93,638 - \$112,140	\$112,141 & Above

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	Insurance: Medicaid, Medicare, BCBS, CHIP, etc
		Self		Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	

Total Family Size: # \_\_\_\_\_

**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 FIXED DISCOUNT DENTAL SERVICES

NOMINAL FEE	SERVICE	GREEN	BLUE	GRAY	WHITE
		TOTAL COST	TOTAL COST	TOTAL COST	TOTAL COST
\$900	▲ Partial Maxillary Dentures	\$900	\$930	\$960	\$990
\$900	▲ Partial Mandibular Dentures	\$900	\$930	\$960	\$990
\$200	● Repair/Addition to Denture (Per Tooth) (Max 2)	\$200	\$210	\$220	\$230
\$500	▲ Interim PD( Flipper 1-2 Teeth) Partials	\$500	\$530	\$560	\$590
\$780	▲ Any Crown	\$780	\$800	\$820	\$840
\$250	● Permanent Stainless Steel Crown	\$250	\$260	\$270	\$280
\$50	● Pulpal Debridement	\$50	\$60	\$70	\$80
\$50	● Root Canal	\$50	\$60	\$70	\$80
\$250	● Night Guards	\$250	\$260	\$270	\$280
\$250	● Internal Bleaching	\$250	\$260	\$270	\$280

- ▲ 50% of Balance Due at Scheduling – 50% Due at Appointment
- 100% of Balance Due at Scheduling

**Larimore Clinic**  
 607 Towner Avenue  
 Larimore, ND 58251  
 701-343-6418

**Grand Forks Clinic**  
 212 South 4<sup>th</sup> Street, Suite 301  
 Grand Forks, ND 58201  
 701-757-2100

**Grand Forks Dental Clinic**  
 212 South 4<sup>th</sup> Street, Suite 101  
 Grand Forks, ND 58201  
 701-757-2100

**Business Center**  
 212 South 4<sup>th</sup> Street, Suite 200  
 Grand Forks, ND 58201  
 701-757-2800

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