SpectraPlan Application

Spectra HEALTH | Redefining Care

Date: _____

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

Billing Address: _____
City State Zip Code

Phone: (_____) _____-_____ Email: _____

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)
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 PRGM
	GREEN - 100% FPL% 0%-100%	**BLUE - 75% FPL% >100%-133%**	**GRAY - 50% FPL% >133%-167%**	**WHITE - 25% FPL% >167%-200%**	**FPL% > 200%**
FAMILY SIZE	**INCOME**	**INCOME**	**INCOME**	**INCOME**	**INCOME**
1	$0 - $14,580	$14,581 - $19,391	$19,392 - $24,349	$24,350 - $29,160	$29,161 & Above
2	$0 - $19,720	$19,721 - $26,228	$26,229 - $32,932	$32,933 - $39,440	$39,441 & Above
3	$0 -$24,860	$24,861 - $33,064	$33,065 - $41,516	$41,517 - $49,720	$49,721 & Above
4	$0 -$30,000	$30,001- $39,900	$39,901 - $50,100	$50,101 - $60,000	$60,001 & Above
5	$0 -$35,140	$35,141 - $46,736	$46,737 - $58,684	$58,685 - $70,280	$70,281 & Above
6	$0 -$40,280	$40,281 - $53,572	$53,573 - $67,268	$67,269 - $80,560	$80,561 & Above
7	$0 -$45,420	$45,421 - $60,409	$60,410 - $75,851	$75,852 - $90,840	$90,841 & Above
8	$0 -$50,560	$50,561 - $67,245	$67,246 - $84,435	$84,436 - $101,120	$101,121 & Above
9	$0 -$55,700	$55,701 - $74,081	$74,082 - $93,019	$93,020 - $111,400	$111,401 & Above
10	$0 -$60,840	$60,841 - $80,917	$80,918 -$101,603	$101,604-$121,680	$121,681 & Above

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Redefining Care

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	MRN (if known or applicable)	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: #_____

Total Income: $_____

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Redefining Care

To return your application:

- Via mail: Spectra Health Social Services, 212 S 4th St Ste 200, Grand Forks, ND 58201
- Via email: socialservices@spectrahealth.org
- In-person: Drop off at any of our clinic locations

If you have questions, contact Spectra Health Social Services at 701-757-2100 ext 1218.

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