SpectraPlan Application

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) consecutive paystubs • Letter from employer validating hours/wages
Immigration Income	YES / NO	• Immigration forms I20 or J1 • Refugee Cash Assistance
Self-Employment	YES / NO	• Current income statement • Most recent federal 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 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 - $15,650	$15,651 - $20,815	$20,816 - $26,136	$26,137 - $31,300	$31,301+
2	$0 - $21,150	$21,151 - $28,130	$28,131 - $35,321	$35,322 - $42,300	$42,301+
3	$0 - $26,650	$26,651 - $35,445	$35,446 - $44,506	$44,507 - $53,300	$53,301+
4	$0 - $32,150	$32,151 - $42,760	$42,761 - $53,691	$53,692 - $64,300	$64,301+
5	$0 - $37,650	$37,651 - $50,075	$50,076 - $62,876	$62,877 - $75,300	$75,301+
6	$0 - $43,150	$43,151 - $57,390	$57,391 - $72,061	$72,062 - $86,300	$86,301+
7	$0 - $48,650	$48,651 - $64,705	$64,706 - $81,246	$81,247 - $97,300	$97,301+
8	$0 - $54,150	$54,151 - $72,020	$72,021 - $90,431	$90,432 - $108,300	$108,301+
9	$0 - $59,650	$59,651 - $79,335	$79,336 - $99,616	$99,617 - $119,300	$119,301+
10	$0 - $65,150	$65,151 - $86,650	$86,651 - $108,801	$108,802 - $130,300	$130,301+

MRN or Patient Label

SpectraPlan Application

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: $___________________

Would you like follow up from Spectra Health Social Services to discuss insurance coverage options? ☐ Yes ☐ No ☐ N/A

MRN or Patient Label

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Submit your completed application one of the following ways:

- Mail: Spectra Health Social Services 212 S 4th St Ste 200 Grand Forks ND 58201
- Email: socialservices@spectrahealth.org
- In-person: Drop off at any of our clinic locations
- Complete online application on our website: www.spectrahealth.org

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 (Primary Care - Including Optometry and Chiropractic Care), or $3 (Behavioral Health) that is due at the time of EACH visit. Additionally, I understand that any services processed at Spectra Health may qualify for the SpectraPlan Discount; however, any services that are sent to an outside facility will be my personal financial responsibility.

As the above-named head of household (guarantor), I accept financial responsibility for everyone listed on this application.

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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 employers of all individuals working within the household and/or authorized agencies to confirm provided income information. For purposes of determining SpectraPlan eligibility, I authorize Spectra Health to contact the people listed in my household on this application and share with them the financial information provided in this application. I understand that I will need 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

Please note the SpectraPlan discount program can NOT be applied to reduce any monthly Medicaid recipient liability for those patients for whom this applies.

MRN or Patient Label