

SpectraPlan Application



Redefining Care

Date: _____

Responsible Party: _____

First Name Last 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	EXAMPES OF ACCEPTED DOCUMENTATION
Employment Income	YES / NO	<ul style="list-style-type: none"> Most recent federal income tax return Last (2) consecutive paystubs Letter from employer validating hours/wages
Immigration Income	YES / NO	<ul style="list-style-type: none"> Immigration forms I20 or J1 Refugee Cash Assistance
Self-Employment	YES / NO	<ul style="list-style-type: none"> Current income statement Most recent federal income tax return
Public Assistance –TANF/MFIP	YES / NO	<ul style="list-style-type: none"> Award Letter(s) listing amount received (current year)
Social Security Benefits	YES / NO	<ul style="list-style-type: none"> Award Letter(s) listing amount received (current year)
Unemployment Compensation	YES / NO	<ul style="list-style-type: none"> Benefit Award Letter (current year)
Workers' Compensation	YES / NO	<ul style="list-style-type: none"> Benefit Award Letter (current year)
Retirement/Pension	YES / NO	<ul style="list-style-type: none"> Plan administrator documentation stating monthly benefit amount (current year)
No Income	YES / NO	<ul style="list-style-type: none"> Letter from previous employer documenting last day of employment Form/Letter Verifying Zero Income From Agency/Caseworker (agency letterhead required) Tax Form 4506t

FAMILY SIZE	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%
	INCOME	INCOME	INCOME	INCOME	INCOME
1	\$0 - \$15,960	\$15,961 - \$21,227	\$21,228 - \$26,653	\$26,654 - \$31,920	\$31,921+
2	\$0 - \$21,640	\$21,641 - \$28,781	\$28,782 - \$36,139	\$36,140 - \$43,280	\$43,281+
3	\$0 - \$27,320	\$27,321 - \$36,336	\$36,337 - \$45,624	\$45,625 - \$54,640	\$54,641+
4	\$0 - \$33,000	\$33,001 - \$43,890	\$43,891 - \$55,110	\$55,111 - \$66,000	\$66,001+
5	\$0 - \$38,680	\$38,681 - \$51,444	\$51,445 - \$64,596	\$64,597 - \$77,360	\$77,361+
6	\$0 - \$44,360	\$44,361 - \$58,999	\$59,000 - \$74,081	\$74,082 - \$88,720	\$88,721+
7	\$0 - \$50,040	\$50,041 - \$66,553	\$66,554 - \$83,567	\$83,568 - \$100,080	\$100,081+
8	\$0 - \$55,720	\$55,721 - \$74,108	\$74,109 - \$93,052	\$93,053 - \$111,440	\$111,441+
9	\$0 - \$61,400	\$61,401 - \$81,662	\$81,663 - \$102,538	\$102,539 - \$122,800	\$122,801+
10	\$0 - \$67,080	\$67,081 - \$89,216	\$89,217 - \$112,024	\$112,025 - \$134,160	\$134,161+

MRN or Patient Label

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.

First Name, Last Name	Date of Birth	MRN (if known or applicable)	Relationship	Income Source	Pay Frequency: Daily, Biweekly, Monthly, etc.	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

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 may be a nominal fee of \$30 (Dental), \$20 (Primary Medical Care - Including 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.

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.