MAHEC

FINANCIAL CARE PROGRAM

Compassionate financial support

Thank you for applying to our Financial Care Program!

These documents will need to be turned in before your application can be processed:

- Completed Application
- Proof of Income

Please return all documents to your Patient Financial Advocate within 30 days of your first appointment.

Family Health Center Financial Advocate
Phone: (828) 771-3507
Fax: (828) 407-2640

Mailing Address:
MAHEC Family Health Center
123 Hendersonville Rd
Asheville, NC 28803

Ob/Gyn Specialists Financial Advocate
Phone: (828) 771-5443
Fax: (828) 407-2639

Mailing Address:
MAHEC Ob/Gyn Specialists
119 Hendersonville Rd
Asheville, NC 28803

Dental Health Center at Columbus Financial Advocate
Phone: (828) 722-0003
Fax: (828) 333-5460

Mailing Address:
MAHEC Dental Health Center at Columbus
130 Forest Glenn Drive
Columbus, NC 28722

If you have any questions regarding the Financial Care program, please feel free to contact your Patient Financial Advocate at the numbers listed above.

Thank You!

Financial Care Program

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Sliding Fee Discount Application

It is the policy of MAHEC to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under MAHEC's Charity Care policy. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME		DATE OF BIRTH	
STREET ADDRESS			
CITY	STATE	ZIP	PHONE

Please list spouse and dependents

Name	**Date of birth**	**Needs charity care**	**Current MAHEC patient**
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No
		❑ Yes ❑ No	❑ Yes ❑ No

Annual Household Income for all working adults

Source	Self	Spouse	Other	Total
Last two pay stubs, tax form with schedule C if you are self-employed, or letter from employer				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other other miscellaneous sources				

NOTE: Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (please print) _____ **Date** _____

Signature _____

Office Use Only

Approved by: _____
Date approved: _____
Family size: _____
Income: _____
Approved discount: _____
Date received signed agreement: _____

Verification Check List	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or		
Income: Prior year tax return, two most recent pay stubs, or other		