

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

Thank you for applying to our Sliding Scale Discount 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 Centers and Internal Medicine Financial Advocate

Phone: (828) 771-3507 Fax: (828) 407-2640

Mailing Address: 123 Hendersonville Rd Asheville, NC 28803

Center for Psychiatry and Mental Wellness Financial Advocate

Phone: (828) 771-3460 Fax: (828) 820-8327

Mailing Address: 125 Hendersonville Rd Asheville, NC 28803

Ob/Gyn Specialists Financial Advocate

Phone: (828) 771-5443 Fax: (828) 407-2639

Mailing Address: 119 Hendersonville Rd Asheville, NC 28803

Dental Health Centers Financial Advocate

Phone: (828) 398-5918 Fax: (828) 552-8691

Mailing Address: 123 Hendersonville Rd Asheville, NC 28803

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





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Sliding Fee Discount Application

It is the policy of MAHEC to provide FQHC and essential services Medical, Behavioral Health, and Dental Care 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 FQHC and essential 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 this policy. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME

DATE OF BIRTH

REET ADDRESS					
TY	STATE	ZIP PH	PHONE		
	•				
ase list spouse and de	ependents Date	Needs	Current MAHEC nations		
Name	of birth	Sliding Scale	Current MAHEC patient		
		☐ Yes ☐ No	Yes No		
		☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Yes ☐ No	☐ Yes ☐ No		
		•	l		
		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 co	rrect.		
Name (please print)	Date		
Signature			
Office Use Only			
Approved by:			
Date approved.			
Family size:			
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			

FHC.00003 March 12, 2021