



SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all 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.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

**Family Health Centers
Financial Advocate**

Phone: (828) 771-5502 | Fax: (828) 579-4208

Mailing Address:

123 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

**Center for Psychiatry and Mental Wellness
Financial Advocate**

Phone: (828) 771- 5466 | Fax: (828) 579-4212

Mailing Address:

125 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

**Internal Medicine
Financial Advocate**

Phone: (828) 771-3507 | Fax: (828) 579-3748

Mailing Address:

123 Hendersonville Rd, Asheville, NC 28803



English



Español

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate

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 miscellaneous sources				

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

I acknowledge Dental Laboratory cost are exempt from the Sliding Fee Discount Yes

I certify that the family size and income information shown above is correct and acknowledge providing false information will rescind application of the Sliding Fee Discount Yes

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		