



# MISSOURI DELTA MEDICAL CENTER

## MISSOURI DELTA PHYSICIAN SERVICES – RURAL HEALTH CLINICS SLIDING FEE DISCOUNT APPLICATION

Name of Head of Household: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	
Dependent		Dependent	

### Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, SSI, public assistance, veteran's payments, survivor benefits, pension or retirement income.				
Royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
<b>TOTAL INCOME</b>				

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

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

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OFFICE USE ONLY:	VERIFICATION CHECKLIST:	Yes	No
Identification/Address:	Driver's license, utility bill, employment ID, other		
Income:	Prior year tax return, three most recent pay stubs, or other		
Insurance:	Insurance cards		
Approved Discount:	Date Approved:	Approved By:	