MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI
Sliding Fee Discount Application

_____ _____

Name of Patient **Place of Employment**

_____

Patient Address **City, State, Zip** **Phone**

Please list family members residing together

Name	Date of Birth	Name	Date of Birth

Income Information

	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, veterans' payments, survivor benefits, pension, or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

Income verification required: One of the following: Prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals should submit 3 months of income and expenses for the business.

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

Name (Print): _____ Date: _____

Signature: _____

Fax completed form and any documentation to 472-7740

Office Use Only

Patient Name: _____ Approved by: _____
Approved Discount: _____ Approved Date: To_____From_____

Verification Checklist:	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		