Missouri Delta Physician Services – RURAL HEALTH CLINIC
Sliding Fee Discount Application

Patient Name _____ **Patient date of birth** _____ **Patient Employer** _____

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

List all individuals residing in household:

Relationship to Patient	Name	Date of Birth

Annual Income Information (for all applicable household members) **Relationship to Patient:**

SOURCE				
Gross annual wages, salaries, tips, earnings				
Unemployment, workers compensation, Social Security, SSI, Veteran's, survivor benefits, pension or retirement, public assistance				
Interest, rents, royalties, trusts, educational assistance, alimony/child support				
Outside the household, 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: _____

Office Use Only – Fax completed form and documentation to 472-7710

Patient Name: _____ Date of Service: _____

Rural Health Clinic Name: _____ Received/Completed Date: _____

Verification Checklist:	Yes	No	RHC staff Initial
Identification/Address: Driver's license, utility bill, employment ID, other			
Income: **One** of the above listed income sources			
Insurance: Insurance Cards			

Business Office Use Only:

Approved: _____ Denied: _____ Processed by: _____

Approved Discount: _____ Dates: From _____ to _____

Responsible for % of Charges: _____ Notification to patient: _____