



SLIDING FEE PROGRAM

PO Box 180
Battiest, OK 74722
(580)241-5294
(580)241-5739 FAX
www.kiamichimed.org

Self Employed Proof of Income

Business Name: _____

Business Owner(s): _____

Business Address: _____

Business Phone: _____

Brief Description of Business: _____

Last/Previous Month's GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, NOT the business gross):

Month/Year: _____ 20 _____ \$ _____

Signed: _____

Date: _____