Christ Health

LETTER OF SUPPORT

Date: _____

PATIENT NAME: _____

DOB: _____

To Whom It May Concern:

The above-named patient is currently living with me. To the best of my knowledge, this patient currently has zero income and is unable to afford to pay for their medical expenses due to financial hardship. The patient also has no insurance coverage to help pay for the cost of medical expenses. By signing this Letter of Support below I certify that (*check yes or no*):

I provide financial support to the above-named patient.

___ **YES**

___ **NO**

I certify that the information contained above is true, complete and correct to the best of my knowledge. Inquiries may be made to verify the statements herein. I do understand that false statements or omissions may be forms of fraud and may be prosecuted under current laws. I understand this Letter of Support will last 1 year, at which time I may be asked to provide this Letter of Support again.

Name of Supporter:_____ Relationship to Patient:_____

_____ _____

Signature of Patient Signature of Supporter

Patient should also complete the Self-Declaration of No Income form.