LETTER OF SUPPORT

Date:_____

Applicant's Name:_____**Applicant's DOB**:_____

Supporter's Name:_____

Supporter's Relationship to Applicant:_____

Supporter's Phone Number:_____

This letter is to certify that (patient's name):_____ receives too little/no income and that I am assisting with his/her living expenses.

Please check one of the following:

- ☐ **Option 1:** Applicant lives with me and I provide all financial support housing, utilities, food and other expenses.
- ☐ **Option 2:** I provide the applicant with $_____ per month in financial assistance.

Signature of Supporter:_____ **Date:**_____