Baptist Community
Health Services

LETTER OF SUPPORT

Date: _____

PATIENT NAME: _____

DOB: _____

To Whom It May Concern:

The above-named patient is currently living with me. In accordance with your eligibility criteria and 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 either. Please select the following:

A. I provide financial support to the above-named patient. (If yes, proof of income is needed to verify.) **YES or NO**

B. I do not provide any financial support to above named patient. (Please refer patient to the Self-Declaration of No Income form.) **YES or 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 or omissions are forms for disqualification and/or may be prosecuted under current laws. I understand this agreement will last 1 year, at which time I will be required to either provide the necessary documentation or renew this agreement.

Thank you for your assistance.

_____ _____

Signature of Patient Signature of Supporter