

Lloyd F. Moss Free Clinic
1301 Sam Perry Boulevard
Fredericksburg, VA 22401

LETTER OF SUPPORT

Date: ____ / ____ / ____ Patient's SSN: ____ - ____ - ____

I, _____, provide the patient
(Supporter's Name)

_____ with the following services.
(Patient's Name)

Check all that apply:

Patient lives with me at my residence in Fredericksburg, Caroline, King George, Spotsylvania, or Stafford. (Supporter must provide proof of CURRENT residency.)

Food
Housing/Rent
Financial Support
Transportation
Other _____

The patient's supporter must complete the section below and provide current identification. (Eligibility Screeners: please make a copy of proof of residency.)

Name _____
(please print)

Address _____

Phone _____

Relationship to Patient _____

Signature _____