



## LETTER OF SUPPORT

Patient's Name: \_\_\_\_\_ Patient's SSN \_\_\_\_\_

-- (The following to be completed by the person who helps support you) --

I, \_\_\_\_\_, certify that I currently reside in:

\_\_\_ City of Fredericksburg \_\_\_ Caroline \_\_\_ King George \_\_\_ Spotsylvania \_\_\_ Stafford

and provide the patient with the following services (check all that apply):

- The patient lives with me
- Food
- Housing/Rent
- Transportation
- Financial / Other:

(Describe other) \_\_\_\_\_

Supporter's

Street Address: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_ ( Home / Cell / Work )

Supporter's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Supporter: Please attach a valid picture ID showing your current address)**

**Valid for 6 months after date signed *or* when the patient's eligibility expires or changes.**