

LETTER OF SUPPORT FOR LIVING WATER COMMUNITY CLINIC

Patient Information:

| | | |
|-----------------------|-------------|-------------|
| Patient Name: (First) | (Last) | Middle Int. |
| Street Address: | City: | State: VA |
| Home Pho.: () | Cell #: () | |

I have no income at present due to the following circumstances: _____

At present I: rent ____ own ___, live with someone ____ (check one)

I am presently residing with: _____ (if applicable)
(name of person you are living with)

Sponsor (supporter) Information:

| | |
|------------------------------------|--------|
| Sponsor Name: | Phone: |
| Address: (if different from above) | |

Below are the items that are covered by my Sponsor:

(Check off and enter estimated dollar amounts to all that apply)

| | | | |
|-----------------------------|-------------------|-------------------------------|------------------------------|
| ___ food \$ _____ | ___ rent \$ _____ | ___ clothing \$ _____ | ___ gas \$ _____ |
| ___ utilities \$ _____ | ___ cash \$ _____ | ___ doctor visits \$ _____ | ___ other (list) \$ _____ |
| ___ medications \$ _____ | | | |

We verify that the above information is current and true.

Patient Signature: _____ **Date:** _____

***Sponsor Signature:** _____ **Date:** _____

Notary: _____ **Date:** _____