



001LOS



PATIENT FINANCIAL SERVICES  
P.O. BOX 800750  
CHARLOTTESVILLE, VA 22908-0750  
FAX: (434) 924-9322  
1-866-320-9659

**LETTER OF SUPPORT**

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEDICAL HISTORY #: \_\_\_\_\_

---

I currently provide food and lodging for the person named above. To the best of my knowledge, he /she has no other means of support or income.

SIGNATURE OF SUPPORT PROVIDER \_\_\_\_\_

DATE: \_\_\_\_\_

PRINTED NAME OF SUPPORT PROVIDER \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*\* SIGNING THIS FORM DOES NOT MAKE YOU RESPONSIBLE FOR ANY BILLS \*\*\***

Esta forma está disponible en Español. Para solicitar, por favor llamar al 1-866-320-9659  
This form is available in Spanish. To request, please call 1-866-320-9659

Letter of Support  
Carta de Apoyo Financiero