SUPPORT LETTER

To Whom It May Concern:

Your name has been given to **CrossOver Healthcare Ministry** concerning the support you are providing for _____.
(Clinic Name) (Patient Name)

In order for us to complete the eligibility determination which allows us to provide any necessary care and/or medications, we need you to complete the bottom of this letter. This letter must be **signed in the presence of and notarized by a public notary**. You can find a public notary at a bank, funeral establishment or courthouse. Please give the notarized form to the person that you are providing assistance for, so they can also bring it to our Clinic at their next appointment.

We appreciate your cooperation in this matter and assure you that all information you give us will be kept confidential.

I _____ am providing _____ with
(provider name) (patient name)

_____ as of _____.
(type of assistance, i.e. rent/housing, food, utilities, etc.) (date)

Relationship to patient: _____Friend
_____Relative
_____Other (explain)_____

I am in no way responsible for their medical bills or other health related costs.

_____
(Signature of provider)

_____
(Print Name of provider)

_____
(Date)

Notary Seal

Given under my hand this ____day of_____,
in the county/city of_____.
Notary Public #_____
Notary Signature_____
My commission expires,_____