Three Angels Clinic
Letter of Support and Patient Financial Information

Patient Name: ____

Supporting Person or Entity - Please Print Your Name(s) Below:

I/we, ____ provide the following support, without any charge or exchange, to the above person:
___ Housing
___ Food
___ Expenses

Estimated total monthly value of above support: $ ________________

I understand that by signing this letter of support for the above-named patient, it **does not** obligate me to pay for the healthcare services provided to the patient by Three Angels Clinic.

The purpose of this letter of support is to assist the patient in qualifying for the Three Angels Clinic, a free volunteer healthcare clinic for the financially qualified uninsured residents of Marion county.

*I understand that it is a violation of the law to provide false information to **Three Angels Clinic** in order to obtain the State of Florida Volunteer Health Care Provider Program health benefits for any person through the **Three Angels Clinic**.*

*I also understand that, at the discretion of **Three Angels Clinic**, I may be asked to verify the above listed support.*

Signature: ____ Date:____________________

Relationship to Patient (if any): ____

Florida Driver License #: ____

Address: ____

City: __________________________________ State: ______________ Zip:____________

(Revised 3/23/15)