

**HAMILTON HEALTHCARE SYSTEM CHARITY CARE
STATEMENT OF SUPPORT**

*Must be notarized if NOT completed in front of charity care staff.

I/WE _____ assist _____
(Household providing support) (Applying individual)

By providing the following: (Check ALL sections either Yes or No)

Yes _____ No _____ CASH How much per month? _____

Yes _____ No _____ PAYMENT OF MEDICAL BILLS AND/OR PRESCRIPTIONS.

Yes _____ No _____ PAYMENT OF UTILITIES

Yes _____ No _____ FOOD AND/OR CLOTHING

Yes _____ No _____ PAYMENT OF HOUSE LOAN OR RENT

Yes _____ No _____ OTHER (PLEASE EXPLAIN) _____

Yes _____ No _____ The above household DOES live with me/us. He/She has lived with Me/Us since _____.
Month, Day, Year

The above household intends to reside at the above address for the following amount of time _____.
Days, Months, Years

Yes _____ No _____ The above household DOES NOT live with me/us.

Signature of person applying Date

Signature of household providing support Date

Signature of charity care staff witnessing signature Date

Before me, the undersigned authority did personally appear _____ and _____, who upon oath, swears that the foregoing statement is true and correct. Signed this _____ day of _____, State of Texas.

NOTARY PUBLIC DATE
My commission expires: _____ 20____