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 UTILITES

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___