



LIVING WATER COMMUNITY CLINIC

Letter of Support

Patient Information:

Patient Name: (First)	(Last)	Middle Int.
Street Address:	City:	State: VA
Home Ph.: ()	Cell #: ()	

I have no income at present due to the following circumstances: _____

At present I: rent ___ own __, live with someone ___ (check one)

I am presently residing with: _____ (if applicable)
(name of person you are living with)

Sponsor (supporter) Information:

Sponsor Name:	Phone:
Address: (if different from above)	

Below are the items that are covered by my Sponsor:

(Check off and enter estimated dollar amounts to all that apply)

___ food \$ _____	___ rent \$ _____	___ clothing \$ _____	___ gas \$ _____
___ utilities \$ _____	___ cash \$ _____	___ doctor visits \$ _____	___ other (list) \$ _____
___ medications \$ _____			

Both signatures must be witnessed. If you and your sponsor can sign this form at the clinic, we will be able to witness your signatures for you in #1 below:

However, if you and your sponsor are signing this form outside of the clinic, your signatures must be notarized in #2.

#1 - By our signature below, we confirm that the information listed above is accurate:

Patient Signature: _____ Date: _____

Sponsor Signature: _____ Date: _____

Two witnesses: _____ Date: _____

_____ Date: _____

#2 - By our signature below, we confirm that the information listed above is accurate:

Patient Signature: _____

Date: _____

Sponsor Signature: _____

Date: _____

Notarial Certificate:

County of _____

Sworn to and subscribed before me on the _____ date of _____, 20____, by
_____ (Name of Principal Signer).

(seal)

Notary Public Signature