# *SPACE COAST VOLUNTEERS IN MEDICINE CLINIC (SpaceCoastVIM)*

## 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 SpaceCoastVIM.

The purpose of this letter of support is to assist the patient in qualifying for the SpaceCoastVIM clinic, a free volunteer healthcare clinic for the financially qualified uninsured residents of Brevard County.

*I understand that it is a violation of the law to provide false information to **Space Coast Volunteers in Medicine** in order to obtain the State of Florida Volunteer Health Care Provider Program health benefits for any person through the SpaceCoastVIM clinic.*

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

Signature: _____ Date: _____

Relationship to Patient (if any): _____

Florida Driver's License #: _____

Address: _____

City: _____ State: _____ Zip: _____

(Revised 3/21/2011)