Space Coast Volunteers in Medicine

LETTER OF SUPPORT and PATIENT FINANCIAL INFORMATION

Patient Name: _____

Supporting Entity or Person (print name): I/We, _____

_____

provide the following support, without any charge or exchange, to the above person:

_____ Housing

_____ Food

_____ Expenses

Estimated total monthly value of above ($): _____

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 the Space Coast Volunteers in Medicine (SCVIM) clinic.

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

I understand that it is a violation of 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 SCVIM clinic.

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

Signature(s): _____

Relationship to Patient (if any): _____

Date: _____

Florida Driver's License Number(s): _____

Address: _____