NACOGDOCHES COUNTY HOSPITAL DISTRICT INDIGENT PROGRAM

LETTER OF SUPPORT VERIFICATION

This form must be completed by any person helping to support the below mentioned applicant.
Please complete all information requested below, including the applicant's name and address.

Applicant's Name: _____

Applicant's Address: _____

1. Are you related to the applicant, if yes, how?_____

2. Does this person live with you? _____Yes _____No How Long? _____

3. Does he/she pay rent? _____Yes _____No How Much?_____

   Utilities? _____Yes _____No How Much?_____

   Phone? _____Yes _____No How Much?_____

4. If you have paid any bills for this applicant, please state the type of bill, to whom it was paid, and the date:

   _____

5. Have you ____**loaned** or ____**given** (CHECK ONE) any money to the client? _____Yes _____No

   How Much? _____ When? _____ Why? _____

6 Does the applicant purchase and prepare food separately from you? _____Yes No_____

7. Is the applicant working? _____Yes _____No Where?_____

8. Have you assisted the applicant in any other way? Please state here, how:_____

   _____

_____ _____ _____
Printed Name Signature Date

_____ (_____)_____
Address Phone Number

THIS FORM MUST BE NOTARIZED
State of Texas
County of Nacogdoches County

Before me, a notary public, on this day personally appeared _____.
Known to me to be the person whose name is subscribed to the foregoing instrument(s), and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20_____.

_____ _____
Notary Public My Commission Expires