Cooper University Health Care

Recognition/Statement of Support

Patient Name: _____ **Account Number:** _____

Date of Service: _____

My name is _____. I certify that I am providing the following type of support and assistance to the above named individual. I recognize the individual to be the patient named above.

I am not responsible, nor able to pay for any hospital or medical expenses for him/her.

From: _____/_____/_____ **to:** _____/_____/_____.

	YES	NO		
Food:	☐	☐		
Shelter:	☐	☐		
Cash:	☐	☐	$_____	_____
			amount	**frequency**

I currently reside at the following address: _____

_____

To Whom It May Concern:

_____

_____

_____

_____ _____

Landlord/Supporter Signature **Phone**

_____ _____

Print Name **Date**

_____ _____

Patient Signature **Date**