Family Care Center
UH HEALTH

Statement of Support

Patient's Name:	
Supporter's Name:	
Relationship to Patient:	
Frequency of Support (circle one):	Weekly Monthly Yearly

Please select the type of support you provide (select all that apply):

☐ I do provide room & board. ☐ I do **NOT** provide room & board.
☐ I do give him/her money: Amount: _____ ☐ I do **NOT** give him/her money. ☐ I pay the household expenses directly.
☐ Other (Please Explain):

I can be reached at the following telephone number to verify this information:

(_____) _____ - _____.

_____ _____

Supporter's Signature Date

UH Health Family Care Center Staff Use Only:

MRN:_____ Date Verified_____ UH Family Care Center Staff Initials_____