Ascension Saint Thomas

Letter of support

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To Ascension Saint Thomas Rehabilitation Hospital:

This letter is to advise that (patient's name)_____receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____