Helen Farabee Centers
Letter of Support

Client: _____ Case #: _____

I provide the following assistance (check all that apply):

☐ Housing This individual lives with me: ◯ YES ◯ NO

☐ Food This individual receives food stamps: ◯ YES ◯ NO

☐ Utilities

☐ Medical Bills/Prescriptions

☐ Give cash to client in the amount of: _____ How often? _____

I plan to provide assistance (check one – cannot be longer than 1 year):

◯ 3 months ◯ 6 months ◯ 9 months ◯ 1 year ◯ Other:_____

_____ _____
Printed Name Signature

_____ _____
Address City State Zip

_____ _____
Phone Number Relationship to Client

_____
Date

The above statements provided by me are true and correct. I understand that this statement will become part of my medical record and that any false entry made with the intent to defraud the Helen Farabee Centers may constitute my paying full charge for all services provided.

_____ _____
Client Signature Date

_____ _____
Legally Authorized Representative Date