



**PROJECT CARE REGIONAL SYSTEM OF CARE
LETTER OF SUPPORT**

Medical Home: Gloucester-Mathews Free Clinic

**LETTER OF SUPPORT FOR INDIVIDUALS WITH NO INCOME
OR NO PROOF OF INCOME**

Date: ____/____/____

I, _____, provide _____,
(Supporter's Name) (Patient's Name)

Address City/State/Zip

with the following services: (Check all that apply)

_____ Food
_____ Housing/Rent
_____ Financial Support

I believe the monthly, dollar value of these services to be approximately
\$_____.

Supporter's address: _____

Supporter's Phone: _____

Relation to Patient: _____

Supporter's Signature: _____

If you receive support (e.g., food, housing, financial support) from a family member or friend, please have the person who helps support you complete this letter. Be sure to bring this letter with you to your eligibility interview. Thank you.

PLEASE REVIEW ADDITIONAL REQUIREMENTS ON NEXT PAGE



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POLICY FOR LETTERS OF SUPPORT

Patient must provide documentation that the person signing this letter of support is a resident of Gloucester or Mathews County. The patient can either:

- Bring the person signing the letter of support to the screening appointment and provide the screener with a picture ID with his/her address.

OR

- If the person signing the letter of support is not available for the screening appointment, the patient can provide a copy of a tax bill, a utility bill, a voter registration card, or a driver's license that shows that the person signing the letter of support lives in the Gloucester Mathews service area.

OR

- If the person signing the letter of support does not live in Gloucester or Mathews County, and only pays for the patient's rent or patient's cost to stay with someone else, the patient must have proof that their residency is in Gloucester or Mathews.