Date_____

I, _____confirm that the individual, _____ is temporarily residing in my home and I am providing food and shelter for this individual due to their present situation. I do not claim this individual as a dependent for tax purposes. I understand that since this individual lives in my home that the proof of the entire household income must be verified to determine financial eligibility. I certify that this information is true and correct to the best of my knowledge.

I understand that United Hospital Center will maintain the confidentiality of any information in this letter and will use this information to determine qualification for participation with United Hospital Center's Patient Assistance Program.

Applicant Signature _____ Date _____

Family/Friend Signature_____ Date _____

Witness Signature _____ Date _____