Willing Helpers Medical Free Clinic
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Phone: 678-625-8317 Fax: 678-487-5824
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Letter of Financial Support-No Income

This form is to be completed for any non-homeless patients who report zero income.
The form should be completed and signed by the person who provides the financial support.

Patient Name: _____ DOB: _____

The person named above states that you provide them with support for their living expenses.
If you provide money directly to the patient or to their landlord or utility company, write that amount.
If the person lives in your home rent-free, you may provide the estimated value using the amount listed.

Housing:	YES / NO	$ _____ per month	(estimate $450 if you provide a room in your home)
Utilities:	YES / NO	$ _____ per month	(estimate $200 if you pay for the utilities in your home)
Food:	YES / NO	$ _____ per month	(estimate $300 if you pay for all of the food in your home)
Medications:	YES / NO	$ _____ per month	
Money:	YES / NO	$ _____ per month	
OTHER:	YES / NO	$ _____ per month	Details: _____

Total estimated monthly financial assistance provided (add all above items): $_____

Financial documents provided: ☐Checking ☐Savings ☐Cash App/Chime/Zelle ☐Other: _____ ☐NONE*

Does the patient reside in your home or in a home owned or rented by you YES / NO

If yes, what is the address of the home: _____

By signing below, I assert the above to be true and correct to the best of my knowledge.

Support Person Name: _____ Relationship: _____

Support Person Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Clinic Rep Signature: _____ Date: _____

Clinic Rep Name: _____