28 White Bridge Road
Suite 400
Nashville, TN 37205
Phone: 615-712-6237
Fax: 615-712-6247

Letter of Support

Date: ____________________ **Referring Clinic:** ____

Applicant's Name: ____

Applicant's DOB: ______________________________ **Applicant's Phone Number:** _________________________

Applicant's Address: ____

Supporter's Name: ____

Supporter's Phone Number: ____________________**Supporter's Relationship to Applicant:** _________________

Project Access Nashville Specialty Care:

This letter is to certify that (*patient's name*) ____
receives little to no income and that I am assisting with his/her living expenses.

Please Check One of the Following:

☐ **Option 1:** Patient lives with me and I provide all financial support for housing, utilities, and food expenses.

☐ **Option 2:** I provide him/her with $_________________ per month.

Signature of Supporter: ____ **Date:** ________________