Montgomery County Hospital District
Healthcare Assistance Program (HCAP)

STATEMENT OF SUPPORT

Client's Name: _____ Clients HCAP #: _____

To Whom This May Concern:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Person of Support's Signature: _____

Person of Support's Phone Number: _____

Witnessed by: _____ Date: _____