

UofL Health Care
University Hospital

PATIENT NAME: _____

PATIENT ACCOUNT NUMBER: _____

To Whom It May Concern:

I, _____, do hereby state that _____ (patient) lives in my household and that I, and/or my spouse, pay all household expenses and that _____ (patient and/or patient's spouse) does not have any income.

Signed: _____

Address: _____

Date: _____

Please Note:

This form must be signed by a notary public

Notary Public: _____

My commission expires: _____