HP LONG
A Service of RAPIDES REGIONAL MEDICAL CENTER

This is to verify that I provide financial support for: _____

(Patients Name)

Who is seeking Financial Assistance for medical care with HP Long.

BELOW IS TO BE FILLED OUT WITH INFO FROM THE PERSON GIVING SUPPORT "NOT THE PATIENT "

SIGNATURE: _____

PRINTED NAME: _____

ADDRESS: _____

_____

PHONE NO. _____

TODAY'S DATE: _____