Olde Towne Medical & Dental Center
5249 Olde Towne Rd, Suite D
Williamsburg, VA 23188
P (757) 259-3258 F (757) 220-1953

Financial Support Letter

We are trying to determine if you give money to any of the following persons:
_____

1. Do you give money to any of the people listed above? Yes [] No []
2. If you do give them money, what is the monthly amount? _____
3. Do you give the same amount each month? Yes [] No []
4. Do you pay any of the following expenses for this person (s)?

Housing	$_____	per month
Utilities	$_____	per month
Medical	$_____	per month
Other	$_____	per month

By completing this form, you are in no way made liable for any debt incurred by the above named person. The information provided will allow the person above to receive a discount on services. Please feel free to contact us with any questions or concerns.

Date: _____

Signature of person completing this form_____

Relationship to person you are assisting _____

Telephone # of person completing form_____

Address of person completing this form_____

_____

_____