Stony Brook Medicine

Stony Brook Medicine Letter of Support

Patient Name:

Person Providing Support: ____

Person Providing Support Contact Information: (   )________________

Signature of Person Providing Support: _____________________________

I provide the above-named patient support for the following items. Please complete each section that applies:

	Support Type (Check all that Apply)	**Dollar Amount**
Shelter		
Food		
Pays bills on behalf of patient		
Funds to pay bills		

If you have questions regarding your Financial Assistance application, please contact our Financial Assistance department at 631-444-4151 during the hours of 8:00 am – 5:00 pm. Monday through Friday.

Sincerely,

Stony Brook Financial Assistance Department