

Dispensary of HOPE- Saint Thomas Hospital West
(Administered by Plaza Pharmacy)
4230 Harding Road Suite A214
Nashville, TN 37205
(615) 222-6216
(615) 222-6189 (fax)

LETTER OF SUPPORT

Patient Name: _____ Birthdate: _____
Address: _____ Apt. _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Cell: _____

Patient Name _____ has no proof of income due to the following reasons:

Please check all appropriate lines:

- _____ Unemployed/Dismissed from work (**must show** unemployment papers)
- _____ Disabled/Applying for disability (**must show** disability papers)
- _____ Student (**must show** proof of enrollment/student loans)
- _____ Paid in Cash (**must provide** letter from employer)
- _____ Other Circumstances/Explain _____

I, _____, certify that I provide the following for
_____:

Please check all appropriate lines:

- _____ Cash \$ _____ per month
- _____ Rent \$ _____ per month
- _____ Food \$ _____ per month
- _____ Utilities \$ _____ per month
- _____ Other Bills \$ _____ per month
- _____ Other Explain _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____