Room and Board / Financial Assistance Statement

PLEASE NOTE: THIS DOCUMENT MUST BE **NOTARIZED**

Cook County Health is here to support our community and patients by providing supplementary health insurance coverage when needed. **We care for all patients, regardless of their race or immigration status**. In order to provide assistance, we need your help by filling in the necessary information below and notarizing this document.

Date: ____________________

This is to inform you that I am the _________________________________ of __________________________.

He/She has been receiving help from me since ___________________. I provide ___________________________.

Although I provide the above, I am not, nor have I ever been financially able to help with the medical expenses. I assume no responsibility for these expenses.

____
Patient Name

____
Provider of Room & Board / Financial Assistance Signature

____
Street Address

____
City, State, Zip Code

____
Notary Seal

____
Telephone Number

______________________________________ ______________
Notary Pulic Signature Date

Date