

**MUSC/CMH/UMA**  
**SUPPORT/PROVIDER ASSISTANCE STATEMENT**

This form must be completed if you have low income, are unemployed or have a claim pending for disability and must be completed by the person(s)/organization providing the applicant support.

I, \_\_\_\_\_, provide food, lodging and other basic necessities  
(PRINT PROVIDER'S NAME)

for \_\_\_\_\_.  
(PRINT APPLICANT'S NAME)

I certify that I do claim the applicant as a dependent on my income taxes.

I certify that I do NOT claim the above named patient as a dependent on my income taxes.

\_\_\_\_\_  
PRINT PROVIDER'S NAME AND RELATIONSHIP TO APPLICANT

\_\_\_\_\_  
PROVIDER'S ADDRESS AND TELEPHONE NUMBER

\_\_\_\_\_  
PROVIDER'S SIGNATURE AND DATE