Mother of Mercy Free Medical Clinic
Phone: 703-335-2779
Fax: 703-420-8993
www.ccda.net

9380 Forestwood Lane Unit B
Manassas, VA 20110

13900 Church Hill Drive
Woodbridge, VA 22191

Affidavit of Support

I ______________________________________, the _______________________ of
(Name of the person providing support) (Relationship to the patient)

_____________________________________ verify that I am providing financial support
(Name of the Patient)

and/or assistance to satisfy the basic necessities of life.

☐ I provide food, shelter, and clothing every Week Month Quarter Year

☐ I give $__________ in financial support every Week Month Quarter Year

My telephone number is _____________________________ and my address is

____.

I understand that the Mother of Mercy Free Medical Clinic may be in contact with me to verify this information. I also understand that providing false information or information that later proves to be false, will result in the termination of services of the Clinic.

_______________________________________ _______________________
Signature of Person Providing Support Date

_______________________________________ _______________________
Patient Signature Date

Notary Acknowledgement

Commonwealth of Virginia
County of _________________________
The foregoing instrument was acknowledged before me this ____ day of _________________, 20___,
by ______________________________ (name of person providing support).

____
(Signature of Notary Public) Notary Seal

My comisión expires: __________________