

Medical Affidavit of Support

State of [State Name]

County of [County Name]

I, [Your Full Name], residing at [Your Full Address], [City], [State], [Postal Code], being duly sworn, depose and state as follows:

1. Purpose

I am submitting this affidavit in support of [Full Name of Patient] for their medical treatment in [specific location or facility].

2. Relationship

I am related to the patient as [state relationship, e.g., parent, sibling, guardian, friend].

3. Commitment to Cover Medical Expenses

I commit to covering all medical and related expenses incurred by [Full Name of Patient] during their treatment period.

4. Financial Capability

My annual income is approximately [state amount], and I have assets totaling [state amount]. Supporting documents, including bank statements, proof of income, and insurance coverage, are attached.

5. Duration of Support

I will provide support until the completion of [state treatment or recovery phase].

Signature

[Your Full Name]

[Your Signature]

Date: [Insert Date]