### horizontal line**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]