Healthy Mothers, Healthy Babies
Coalition of Broward County, Inc.
Nurturing Mothers, Babies and

CRIBS FOR KIDS®
...it's for the babies

LETTER OF MONETARY SUPPORT

Participant's Name: **(PRINT FULL NAME)** _____

This is to certify that I, **(PRINT FULL NAME)** _____

being the _____ of the above participant _____
(RELATIONSHIP) **(NAME OF PARTICIPANT)**

provides monetary support in the amount of _____ per_____
(ONE TIME, WEEKLY, BI-WEEKLY, MONTHLY, YEARLY)

and/or from: _____ to _____.
(MONTH & YEAR) **(MONTH & YEAR)**

My phone number is _____ should verification be required. To my knowledge there is no known income available to this participant other than myself. Please let it be known that the information provided will only be used for the sole purposes of eligibility for the **CRIBS FOR KIDS®** program.

Signature of Supporter: _____

Name of Supporter:_____

STATE OF FLORIDA
COUNTY OF BROWARD
SUBCRIBED AND SWORN TO BEFORE ME
THIS _____ DAY OF _____ 20____

_____ _____
SIGANTURE OF NOTARY PUBLIC **NOTARY STAMP REQUIRED ABOVE**

Healthy Mothers, Healthy Babies Coalition of Broward County, Inc
P.O. Box 350446, Fort Lauderdale, FL 33315
Phone 954-765-0550 ▪ Fax 954-765-0587

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