Request for Medical Debt Relief Program

Date: [Insert Date]

[Your Name]

[Your Address] [City, State, Zip Code]

[Your Email] [Your Phone Number]

[Recipient Name]

[Organization's Name] [Organization's Address] [City, State, Zip Code]

Dear [Recipient Name],

I hope this letter finds you well. I am writing to formally request assistance through the Medical Debt Relief Program due to my current financial hardship resulting from outstanding medical bills.

Due to [briefly explain your situation, e.g., medical issues, loss of job], I have been unable to manage my medical expenses, which has resulted in a significant debt that I am struggling to pay. The total amount of my medical debt is [insert amount], which includes [list types of medical debts].

I have attached the necessary documents, including proof of income and copies of my medical bills, to support my application for relief. I kindly ask for your consideration of my request and intervention in helping reduce or eliminate this burden.

Thank you for your attention to my situation. I am hopeful for your positive response and am willing to provide any further information needed to assist in this matter.

Sincerely,

[Your Name]