



Maria M. Love Convalescent Fund

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Entire form must be completed for consideration. Please print your responses.

AGENCY

Agency Contact: _____ Date: _____

Agency: _____ Phone: _____ Fax: _____

Email Address: _____

Agency Address: _____ City: _____ Zip: _____

Supervisor Verification: _____

SIGNATURE

CLIENT

Client Name: _____ M F Birthdate: ____ / ____ / ____

Address: _____ City: _____ Zip: _____

Medical Diagnosis: _____

Service Requested/Description: *(Please provide as much information as possible)* _____

VENDOR (WHO IS TO BE PAID)

Vendor: _____ Contact: _____

Vendor Address: _____ City: _____ Zip: _____

Vendor Phone: _____ Fax: _____

Item Requested: _____ Amount/Charge: \$ _____

Utility Account #: _____ Client Account #: _____

*** PLEASE FAX ANY BILL STATEMENTS OR DOCUMENTATION OF NEED.**

Client has given permission for release of information: Yes No

All other sources have been explored: Yes No

CONVALESCENT FUND POLICY

- Erie County Resident Only
- This service is available one (1) time only and for a maximum of \$300 or \$200 for utility payments
- Utility restoration or when shut-off notice has been issued

FOR
OFFICE
USE
ONLY

APPROVAL: YES NO DATE OF ACTION: ____ / ____ / ____ AMOUNT OF APPROVAL: \$ _____

CATEGORY: MEDS CC UTILITY TRANSPORT FOOD

ACTION TAKEN: