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: _____ext:_____ 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, QUOTES OR DOCUMENTATION OF NEED.**
Client has given permission for release of information: ☐ Yes ☐ No
All other funding sources have been explored: ☐ Yes ☐ No

CONVALESCENT FUND POLICY

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

FOR OFFICE USE ONLY

APPROVAL: ☐ YES ☐ NO DATE OF ACTION: _____/_____/_____ AMOUNT OF APPROVAL: $ _____
CATEGORY: ☐ MEDS ☐ CC ☐ UTILITY ☐ TRANSPORT ☐ RENT