County of Erie

MARK C. POLONCARZ

COUNTY EXECUTIVE

DEPARTMENT OF SOCIAL SERVICES

RETURN THIS MEDICAL BY: _____/_____/_____

THIS SECTION TO BE COMPLETED BY WORKER

CLIENT NAME: _____ CASE TYPE: SN TANF SN MOE SNAP **(CIRCLE ONE)**

ADDRESS: _____

CASE NO: _____ CIN NO.: _____

PATIENT NAME: _____

WORKER NAME: _____ PHONE NO.: _____

THIS SECTON TO BE COMPLETED BY PHYSICIAN

IS THE ABOVE-NAMED CLIENT NEEDED IN THE HOME TO CARE FOR THE PATIENT LISTED ABOVE (DURING NORMAL DAY WORK HOURS)?

❒ YES ❒ NO

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

MEDICAL CONDITION OF PATIENT: _____

RELATIONSHIP TO CLIENT: _____

ESTIMATE OF DURATION OF NEED IN THE HOME: _____

IF **"YES"** IS INDICATED, PLEASE GIVE REASONS FOR NEED. INCLUDE TASKS CLIENT MUST PERFORM FOR PATIENT.

_____

_____

_____

_____

_____

_____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

PHYSICIAN INFORMATION (PLEASE PRINT)

NAME: _____

ADDRESS: _____

PHONE: (_____) _____-_____

Fax: (_____) _____-_____

PLEASE FORWARD COMPLETED FORM TO:

Erie County Department of Social Services:

☐ **CED** – 290 Main St., 5th Floor, Buffalo, 14202 Fax: 858-1012

☒ **CED** – 290 Main St., 10th Floor, Buffalo 14202 Fax: 858-1065

☐ **MED/MAAT** – 290 Main St., 9th Floor, Buffalo 14202
Fax: (716) 858-1316

☐ **ECWC-EMP.** – 158 Pearl St., Rm.210, Buffalo 14202
Fax:(716) 858-2168

☐ **SNAP** – 95 Franklin, Buffalo Fax: 858-8193

Other:

B-4183 (Rev. 03/17)