SUMMER CRISIS PROGRAM (SCP) MEDICAL ELIGIBILITY FORM

Due to an illness, (patient's name)_____
would benefit from continued electric service and/or air conditioning and/or fan.

PRINT NAME:_____
Medical Professional

SIGN NAME:_____DATE:_____
Medical Professional

NAME OF MEDICAL PRACTICE:_____

ADDRESS:_____

Submission of this Ohio Development Services Agency approved "Medical Eligibility Form" completed by a licensed medical professional who is qualified under Ohio State law to write prescriptions **must be** completed no more than **one year** prior to the client applying for **SCP**.

FOR CHRONIC ILLNESS (Initial here if applicable_____)

(Required Once Every 3 years)

Medical Professional Signature (if applicable): _____
(Required Once Every 3 Years)

Clients whose illness has been determined chronic by a licensed medical professional who is qualified under Ohio State law to write prescriptions shall submit medical documentation once every three years to the Home Energy Assistance Program (HEAP) to receive Summer Crisis Assistance. Clients with a chronic illness must be identified at the time of completing their SCP application.

****Please return this form to Warren County Community Services, Inc. Emergency HEAP Department or have a physician fax to 513-932-0502**.**