

Primary applicant's name _____ phone # _____

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 (1) year prior to the client applying for SCP.

FOR CHRONIC ILLNESS
(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 your local Energy Assistance Provider at the following address/fax/email:**

COMMUNITY ACTION COUNCIL OF PORTAGE COUNTY

1036 WEST MAIN ST ~ PO BOX 917

RAVENNA, Ohio 44266

Ph: 330-297-1456~press 1 for HEAP

Fax: 330-297-1463

We have a dropbox on the Hillcrest side of our building right next to the big garage door.