

SUMMER CRISIS PROGRAM
MEDICAL ELIGIBILITY FORM – 2024



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

Please check whether you are a: Doctor Licensed Medical Professional

Print Name: _____
Medical Professional

Signature: _____ Date: _____
Medical Professional

Name of Medical Practice: _____

Address: _____

Submission of this Ohio Department of Development 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 client applying for **Summer Crisis Program (SCP)**.

FOR CHRONIC ILLNESS

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 Summer Crisis Program application.

Please return this form to the Community Action Agency at the following address/fax/email:

Pathway, Inc.
Attn.: Home Energy Assistance Program
505 Hamilton Street.
Toledo, Ohio 43604-8520
Fax: 419 244 8835
HEAPSM@PathwayToledo.org