SUMMER CRISIS PROGRAM
MEDICAL ELIGIBILITY FORM – 2025

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