



SUMMER CRISIS PROGRAM
MEDICAL ELIGIBILITY FORM – 2026



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

Sign Name: _____ Date: _____
Medical Professional

Name of Medical Practice: _____

Address: _____

Submission of this Ohio Department of Job and Family Services 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 your local Energy Assistance Provider 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