

*****To be completed ONLY if NOT in Disconnect Status*****

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 OCA approved "Medical Eligibility Form" completed by a licensed medical professional, who is qualified under Ohio State Law to write prescriptions, must be issued no more than one (1) year prior to customer applying for Summer Crisis Program (SCP) funds.

FOR CHRONIC ILLNESS (Initial here, if applicable _____)
(Issued 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 resubmit medical documentation only 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 the Community Action Agency at the following address/fax/email:

Supports to Encourage Low-income Families

1790 S Erie Blvd
Suites A-C
Hamilton, Ohio 45011
Phone: 513-868-9300
FAX: 513-737-3889

OR

930 9th Ave
Middletown, Ohio 45044
Phone: 513-217-7930
FAX: 513-217-7935