

**SUMMER CRISIS PROGRAM (SCP) MEDICAL ELIGIBILITY FORM
FOR **CHRONIC** ILLNESS**
(Issued Once Every 3 Years)

*Clients whose illness has been determined chronic by a licensed physician or registered nurse practitioner **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 HEAP application by providing documentation that states the following:*

*Due to a **chronic** illness, **patient's name**, _____
would benefit from continued electric service and/or air conditioning and/or fan.*

Please check whether you are a:
_____ Doctor or _____ Nurse Practitioner

PRINT NAME: _____

SIGN NAME: _____ DATE: _____

NAME OF MEDICAL PRACTICE: _____

ADDRESS: _____

Submission of this OCA approved "Medical Eligibility Form" completed by a licensed physician or registered nurse practitioner **must be** issued no more than **one (1) year** prior to customer applying for **Summer Crisis Program (SCP)** funds.

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

Jackson-Vinton Community Action, Inc.
118 S. New York Avenue
Wellston, Ohio 45692
FAX: 740-384-5815
EMAIL: frontoffice@jvcai.org