



West Ohio Community Action Partnership

540 S. Central Ave.
Lima, Oh 45804

PH: (419) 227-2586
Fax: (419) 277-7626
http: www.wocap.org

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 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 the client applying for 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 SCP application.

****Please return this form to your local Energy Assistance Provider at the following**

Address: 540 S Central Ave Lima, OH 45804

Fax: 419-227-7626

Email: intakedocs@wocap.org