OHIO HEARTLAND COMMUNITY ACTION COMMISSION (OHCAC)
SUMMER CRISIS PROGRAM (SCP)
"Medical Eligibility Form"

Fax to 740-387-3407 MARION COUNTY OHCAC Office: 740-383-2154

IN ACCORDANCE WITH Section 164.508 of the HIPPA Act of 1996, I authorize my physician _____, or registered nurse practitioner_____,
(*Print physician's full name*) (*Print registered nurse practitioner's full name*)
to provide specific information to the ***Ohio Heartland Community Action (OHCAC)***, with the understanding that **OHCAC**, as authorized by the Ohio Department of Development, will provide one (1) month payment of **Electric Bill** for the purpose of alleviating symptoms related to a documented illness suffered by me or other dependent members of my household located at:_____

_____
(Patient's home address)

THE 2017 SCP runs JULY 1 to AUGUST 31, 2017

Today's date is _____.

"It is my professional opinion that my patient would benefit from continued electric service or air conditioning."

_____ _____
Print patient's full name Patient's signature

If Patient is a minor or under guardianship:

_____ _____
Print guardian's/parent's full name Guardian/Parent's signature

PHYSICIAN'S DOCUMENTATION:

❒ **Due to an illness, this client would benefit from continued electric service and/or air conditioning. By checking THIS qualification, I am certifying that this *is valid for a 12-month period!***

❒ **Due to a *CHRONIC* illness, this client would benefit from continued electric service and/or air Conditioning. By checking THIS qualification, I am certifying that this *is valid for 3 years (36 months)!***

- ***Submission of this medical form is valid for one year prior to the customer applying for the 2017 Summer Crisis Program (2017 SCP) funds.***

_____ _____
Physician's name (please print) Office address, city and zip code

_____ _____
Physician's signature Office telephone number and Fax number

*THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY, OTHER THAN PATIENT'S SIGNATURE, BY THE PHYSICIAN OR REGISTERED NURSE PRACTITIONER