

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

Fax to 419-946-2017 to Morrow County OHCAC

Office: 419-946-2009

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**