Intake Name: _____ Client #: _____

Summer Crisis 2019

2999 PAYNE AVNUE, SUITE 208
CLEVELAND, OH 44114

I, _____, here by grant authorization to my physician _____
PRINT FULL NAME PRINT FULL NAME

or other authorized clinic personnel, _____ to provide specific information to
PRINT FULL NAME

CHN Housing Partners and affiliates and/or the Ohio Development Service Agency. I understand this form is to be used solely for the issuance of a cooling unit and/or ***an electric payment*** to benefit the health of a member of the household.

_____ _____ _____
PRINT PATIENT'S FULL NAME SIGNATURE of PATIENT/PARENT or GURDIAN DATE

_____ _____
PRINT PATIENT'S PHONE NUMBER ADDRESS ZIP CODE

PHYSICIAN'S DOCUMENTATION

Submission of this ODSA approved "Medical Eligibility Form" completed by a Licensed Physician or registered Nurse Practitioner/Physician Assistant ***must be*** *completed no more than* ***One (1) year prior*** *to the customer applying for* ***Summer Crisis Program (SCP)****"*

Please check 1 year _____ or 3 year (Chronic) _____

I certify that I have examined the above patient _____ and
PRINT NAME

I have determined that he/she would benefit from receiving a cooling unit and/ or a payment.

_____ _____ _____
PHYSICIAN'S SIGNATURE OFFICE ADDRESS CITY/STATE/ZIP

_____
OFFICE TELEPHONE NUMBERS

XXX-VALIDATION STAMP REQUIRED BY MEDICAL FACILITY- XXX

Agency	Address	Fax
CHN Housing Partners (Main Office)	2999 PAYNE Ave, Suite 134, Cleveland	216-325-6541
BELLAIRE PURITAS	14703 Puritas Ave, Cleveland 44135	216-671-9868
Euclid City Hall	585 E. 222nd St. Euclid, 44123	216-938-7435
Metro west	3167 Fulton Rd, Cleveland, 44109	216-961-9387
FAIRFAX	8111 Quincy Ave, Cleveland, 44104	216-361-8653
Maple Heights Senior Center	15901 Libby Rd. Maple Heights, 44137	216-510-0634