Gateway Community Action Partnership

HOME ENERGY ASSISTANCE PROGRAM
COOLING ASSISTANCE MEDICAL FORM ~ 2014

(This form must be completed by your Doctor)

Head of Household / Applicant's Name ______________________________

Head of Household / Applicant's Social Security # ________ - ________ - ________

Address ______________________________

City ______________________ State ________ Phone # ______________

Patient's Name ______________________________

Patient's Social Security # ________ - ________ - ________

This is to certify that the health of ______________________________
(Patient's name)

will be endanger without Cooling Assistance during the Summer due to:

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(Medical reason must be specific)

Office Stamp (must be stamped)

______________________ Signature of Physician

______________________ Address

______________________ Office Name

______________________ City

______________________ Date

______________________ Phone #