LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)
PHYSICIAN/NURSE MEDICAL STATEMENT

Date: _____

Patient/Client Name:_____

County:_____

Dear Physician/Nurse:

The above-named patient/client has applied for LIHEAP Crisis Assistance. This program provides emergency utility (heating or cooling) assistance to eligible low-income persons who have a verifiable medical situation caused (or aggravated) by extreme heat or cold weather. It is not required that the patient be seen again by you only for the purpose of completing this form. Please complete this form and return to me.

☐ In my opinion, this patient does have a medical situation caused (or aggravated) by extreme heat or cold.

☐ In my opinion, this patient does not have a medical situation caused (or aggravated) by extreme heat or cold.

☐ I cannot make a determination at this time because (Explain):

_____

_____

_____ _____
Physician/Nurse Signature or stamp Date

_____
Printed Name of Physician or Nurse

_____
Phone Number

Sincerely,

_____
Agency Employee

_____
Community Action Agency

LIHEAP-124
October 2018