South Central Community Action Program
SCCAP
Empowering people to reach their potential

Air Conditioner Certification Affidavit

I, _____ (name of doctor or nurse practitioner), hereby certify that my patient, _____, has a medical condition that justifies the need for an air conditioner and that the lack of a room air conditioner in the household may seriously jeopardize the health of that person.

The patient applying for the air conditioner has a medical condition.

_____ _____

Signature of Doctor or Nurse Practitioner **Date**

_____ _____

Phone Number

_____

Mailing Address of Medical Facility

I, _____, understand that I must meet and agree to the following terms and conditions to qualify an air conditioner under the Energy Assistance Summer Cooling Program.

- My household is financially eligible based on the guidelines for the program;
- My household meets one of the following at risk categories: elderly, disabled, or have a child under the age of 6;
- My medical doctor or nurse practitioner has verified that I meet the medical requirements for eligibility and signed the statement above;
- The air conditioner must reside in my household and cannot be sold, transferred, or traded no less than five years from the date listed on this application;
- I understand that I will not qualify for another air conditioner for a period of five years from the date assigned on this application.

_____ _____

Signature Head of Household **Date**

_____ _____

Agency Signature **Date**

ihcda
Indiana Housing & Community Development Authority