Device trial request/funding packet.

Introduction

Thank you for including Lincare AAC® for your device trial. We are excited to partner with you and will do everything in our power to make the process as smooth as as possible. In order to facilitate this, please complete this packet accurately and completely, with all necessary documentation included. Missing, illegible, or incomplete information will cause processing delays. Following are some basic instructions on key pieces of the funding packet as well as a checklist to guide you on your journey. If you have any questions or need assistance, please reach out to us using the contact information on the next page.

The device trial request is the first step in the process. After your trial is successful, you can submit pages 9 through 23, which is the remaining information and paperwork necessary to request a device from your funding source.

How to fill out this form

Please complete the information within this packet accurately and fully, with all necessary documentation included. This packet may be filled out in one of two ways:

Printed: Print all pages, fill out the packet, sign it, then either email or fax the packet along with the required documentation. (Submission instructions on next page.)

PDF form: This packet can be filled out on a computer or tablet (such as an iPad). You must use a program that supports forms. Adobe Acrobat Reader is a free PDF program that is available for all operating systems and is the only program confirmed to work with these forms. Other PDF apps may not be compatible. If you have any questions on compatibility, please contact us.

Signature instructions for PDF forms

After completing this packet, print the entire packet, sign the appropriate forms, then rescan them for submission, unless faxing the paperwork.

Submission instructions

Email all required paperwork in one email to **NHCOrders@lincare.com.**
Fax all required paperwork together to **928.556.0709.**

Once the packet is received and verified, the funding request will be processed.

While Lincare AAC® maintains a secure data environment for electronic information including emails, we cannot guarantee the security of any information, including HIPAA protected or personal information, transmitted via a third party program for email (such as Google, AOL, AT&T, Verizon and others).

Support and contact information

The Lincare AAC team is here to support you in any way we can. Please contact us with any questions.
Email: devicetrial@lincareaac.com
Phone: 877.893.5305 (Monday - Friday, 8 am to 4:30 pm AZ MST)
Online: lincareaac.com

Device trial request checklist.

Device trial request form:

☐ Completed

☐ Attached

Device trial selection form:

☐ Completed

☐ Attached

HIPAA authorization form:

☐ Completed

☐ Attached

Equipment loan agreement:

☐ Completed

☐ Attached

Copies of all insurance cards:

☐ Attached (Clear copies of the front and back of all cards)

Power of Attorney paperwork:

☐ Attached (Required if Power of Attorney is signing)

Device trial request form.

Section 1: Client information

Name (first and last): _____ Date of birth: _____

Preferred pronouns (optional): _____ Customer ID (internal use only): _____

Primary language: _____ Hard of hearing: ☐ Yes ☐ No

Legally responsible/Contact person (if applicable)

Name: _____ Relationship to client: _____

Contact email address: _____

Primary contact phone number type: ☐ Home/office ☐ Mobile

Phone number: _____ Extension: _____

Secondary contact phone number type: ☐ Home/office ☐ Mobile

Secondary phone number: _____ Extension: _____

Residence address: _____

City: _____ State: _____ Zip: _____

☐ Shipping address is the same as the residence address. We cannot ship to a PO box, and Medicare-funded devices must be shipped to the patient's residence address. (Skip to "Place of Residence".)

Shipping address: _____

City: _____ State: _____ Zip: _____

Place of residence:

☐ Home ☐ Custodial care facility ☐ Assisted living facility ☐ Group home

☐ Intermediate care facilities for individuals with intellectual disabilities ☐ Skilled nursing facility ☐ Hospice

☐ Other: _____

Do you own, or have you previously owned, a communication device? ☐ Yes ☐ No

Section 2: Client diagnosis information (Include ICD-10 codes)

Medical diagnosis: _____ Date of onset: _____

Communication diagnosis: _____ Date of onset: _____

Is diagnosis the result of an accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: _____

Section 3: Speech-language pathologist information

Name (first and last): _____ Email: _____

Facility name: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____

State and license number: _____ ASHA number: _____

Section 4: Insurance information

Check and fill out only applicable sections. Fill out address only if different from client.

☐ Medicare ID number: _____ Medicare managed care? ☐ Yes ☐ No

☐ Medicaid ID number: _____ Medicaid managed care? ☐ Yes ☐ No

Name of managed care organization: _____

☐ Primary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

☐ Secondary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Device trial device selection form.

Expression Series device

☐ Expression Micro ☐ Expression Mini ☐ Expression Classic ☐ Expression Supreme

Eye gaze systems

☐ Contact the evaluating speech-language pathologist to identify a trial device.

Preferred method (all that apply): ☐ Email ☐ Primary phone ☐ Secondary phone

Communication apps requested

Please list all apps requested for the trial period.

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

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Customer ID: _____

HIPAA authorization form.

Patient name (first, last): _____ Patient DOB: _____

This form will be retained in your medical record.
In accordance with the HIPAA Privacy Regulations, applicable state laws, and our Notice of Privacy Practices, "the Company" is required to maintain the privacy of your protected health information.

For us to protect the privacy of your health and account information related to your medical treatment, several authorizations will need to be provided.

Authorization to leave health information via voice messages.

☐ Yes, I authorize "the Company" to leave voice messages concerning my heath information (i.e., test results, appointments/visits, etc.) at the following number for myself: _____. If yes, then number required.
Patient contact number

1. My health and account information may be used by the person(s) I authorize to receive this information for medical treatment, billing or claims payment, or other purposes as I may direct.

I hereby authorize the following individual(s) to receive verbal and/or written communications from "the Company" that may include health and/or account information about me:

Individual's name (first, last): _____ Relationship to patient: _____

Contact number: _____

Individual's name (first, last): _____ Relationship to patient: _____

Contact number: _____

This authorization shall be in force and effect until (check one):

☐ My services are concluded, and billing is resolved; or

☐ _____ (a specific date) or _____ (event), at which time this authorization expires.

I understand I have the right to revoke this authorization, in writing, at any time. The extent of this authorization is as follows (check one):

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse); or

☐ I authorize the release of my complete health record except for the following information (check all that you choose to exclude, if any):

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS) ☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

This acknowledgment must be completed and signed by the patient. If the patient is unable to sign this consent form, the patient's Power of Attorney may complete and sign it.

Signature of patient or POA: _____

Printed name of patient or POA (first, last): _____ Date: _____

For office use only. I attempted to obtain written consent for disclosures of protected health information, but the consent could not be obtained because: ☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment

☐ An emergency situation prevented us from obtaining the consent

☐ Other (please specify): _____

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Equipment loan agreement.

This EQUIPMENT LOAN AGREEMENT ("Agreement") is made as of the date of the last signature below by and between RCS Management Corp d/b/a Lincare AAC ("Lincare AAC") and _____("Borrower"), having an address at _____.

Lincare AAC and Borrower may be referenced collectively in this Agreement as the "Parties" or each individually as a "Party."

1. **Equipment.** Subject to all terms and conditions of this Agreement, Lincare AAC will loan to Borrower the equipment specified on the attached Exhibit A (the "Equipment"). At the end of the Term, Borrower shall return the Equipment in its original condition, ordinary wear and tear excepted. The Equipment is to be used only for the permitted use below.

2. **Term and Termination.** The term ("Term") of this Agreement shall be for ninety (90) days beginning on _____. The parties can extend the term for one more ninety (90) day period; but in no event will the term be longer than one (1) year unless specifically required by regulation. Either Party may terminate this Agreement at any time by giving 15 days' written notice to the other Party. In addition, Lincare AAC may terminate this Agreement immediately in the event of Borrower's failure to comply with any of the terms and conditions of this Agreement.

3. **Permitted Use.** The Equipment shall be used solely for the purpose of a trial device and is not be utilized for evaluation of a particular patient or provided as a permanent device to a particular patient. Borrower represents to Lincare AAC that Borrower and/or its personnel are appropriately licensed and qualified to perform such trials using the Equipment.

4. **Responsibility for Loss or Damage.** Borrower shall keep Equipment free and clear of all claims, liens, encumbrances and legal processes of every type whatsoever. Borrower shall not remove from the Equipment any stencils, plates, labels, marks, trademarks, or other indicia of ownership identifying Lincare AAC. Borrower is responsible for any loss or damage to the Equipment from the time Borrower takes possession of it until it is returned to the possession of Lincare AAC. Lincare AAC will charge Borrower the full value of the Equipment for any lost or damaged Equipment. Equipment shall be considered lost if not returned to Lincare AAC within thirty (30) days of the termination of this Agreement, and Borrower shall be charged the full value for the Equipment.

5. **Indemnification.** Lincare AAC makes no representation or warranty regarding the Equipment while in use by Borrower. Borrower accepts all risks to itself and to any third parties that may result or arise out of the possession or use of the Equipment and agrees to indemnify and save harmless Lincare AAC, its officers, agents, and employees from all loss, cost and expense arising out of any liability or claim of liability for damages to person or property arising out of its possession or use of the Equipment.

6. **Assignment.** This Agreement is personal, and Borrower shall not assign this Agreement, or any privileges granted hereunder without the prior written consent of Lincare AAC.

7. **Miscellaneous.** The interpretation and performance of this Agreement shall be governed by the laws of the State of Florida, without giving effect to its conflicts of law provisions. No amendment or modification of this Agreement or waiver of the terms or conditions hereof shall be binding upon any party unless approved in writing by an authorized representative of such party.

IN WITNESS WHEREOF, Lincare AAC and Borrower have executed this Agreement as of the date of the last signature below as indicated by the signatures of their authorized representatives.

Borrower:

Signature: _____

Printed name: _____

Relationship to client: _____

Date: _____

RCS Management Corp (internal use only):

Signature: _____

Printed name: _____

Title: _____

Date: _____

Printed name of the patient referenced in Pargraph #3: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

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Funding instructions.

Introduction

We are happy that your trial was a success and that you have identified a suitable device for your client. The remaining pages will guide you through the remainder of the process necessary to complete the funding request. Your client may keep the trial device until they receive their funded device so they can continue to learn and communicate during the funding process.

Apple ID requirements

Lincare AAC® may create an Apple ID to facilitate distribution of the prescribed communication apps. An agreement for usage terms of the Apple ID are included and must be signed in order to submit for funding.

Trusted phone number

Apple requires a “Trusted Phone Number” for their two-factor authentication security measure. This may be a home, office, or mobile phone number. Additionally, it should be a phone number you can access readily as it may used to verify the user’s authenticity. This is an Apple requirement and Lincare AAC has no control over it.

Important note: The following form will ask you to select which phone number you want as your trusted phone number and you must select one. You may receive a confirmation code on your trusted phone number prior to receiving your device. This is part of the setup process, and no action is required on your part; please disregard it.

Submission instructions

Email all required paperwork in one email to **NHCOrders@lincare.com.**
Fax all required paperwork together to **928.556.0709.**

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Support and contact information

The Lincare AAC team is here to support you in any way we can. Please contact us with any questions.
Email: devicetrial@lincareaac.com
Phone: 877.893.5305 (Monday - Friday, 8 am to 4:30 pm AZ MST)
Online: lincareaac.com

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Post-trial funding request checklist.

Post-trial funding request:
☐ Completed
☐ Attached

Patient agreement and consent:
☐ Completed
☐ Attached

Patient rights and responsibilities:

Lifetime Release/Assignment of Benefits/Payment Agreement:
☐ Completed
☐ Attached

Apple ID creation and usage policy:
☐ Completed
☐ Attached

Speech-generating device DME prescription (from this packet or physician's own prescription):
☐ Completed
☐ Attached

SLP evaluation (written using the SGD evaluation criteria included with this package):
☐ Attached

Notice of privacy practices:
☐ Completed
☐ Attached

Medicare DMEPOS supplier standards

Warranty and returns information

Copies of all insurance cards (clear copies of the front and back of all cards):
☐ Attached

Physician's face-to-face examination notes (if applicable):
☐ Attached

State Medicaid form (if applicable):
☐ Attached

Power of Attorney paperwork (required if Power of Attorney is signing):
☐ Attached

Post-trial funding request.

Section 1: Client/contact information

Name (first and last): _____ Date of birth: _____

Preferred pronouns (optional): _____ Customer ID (internal use only): _____

Primary language: _____ Hard of hearing: ☐ Yes ☐ No

☐ **Client information has not changed from the trial request form. (Skip to section 2.)**

☐ **I have updated new or changed information below.**

Legally responsible/Contact person (if applicable)

Name: _____ Relationship to client: _____

Contact email address: _____

Primary contact phone number type: ☐ Home/office ☐ Mobile

Phone number: _____ Extension: _____

Secondary contact phone number type: ☐ Home/office ☐ Mobile

Secondary phone number: _____ Extension: _____

Trusted phone number: ☐ Use primary phone number ☐ Use secondary phone number

Residence address: _____

City: _____ State: _____ Zip: _____

☐ Shipping address is the same as the residence address. We cannot ship to a PO box. Medicare funded devices must be shipped to the patient's residence address. (Skip to "Place of Residence".)

Shipping address: _____

City: _____ State: _____ Zip: _____

Place of residence:

☐ Home ☐ Custodial care facility ☐ Assisted living facility ☐ Group home

☐ Intermediate care facilities for individuals with intellectual disabilities ☐ Skilled nursing facility ☐ Hospice

☐ Other: _____

Do you own, or have you previously owned, a communication device? ☐ Yes ☐ No

Section 2: Client diagnosis information (include ICD-10 codes)

☐ **Client diagnosis information has not changed. (Skip to section 3.)**

☐ **I have updated new or changed information below.**

Medical diagnosis: _____ Date of onset: _____

Communication diagnosis: _____ Date of onset: _____

Is diagnosis the result of an accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: _____

Section 3: Speech-language pathologist information

☐ **Speech-language pathologist information has not changed. (Skip to section 4.)**

☐ **I have updated new or changed information below.**

Name (first and last): _____ Email: _____

Facility name: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____

State and license number: _____ ASHA number: _____

Section 4: Insurance information

☐ **Insurance information has not changed. (Skip to section 5.)**

☐ **I have updated new or changed information below.**

Check and fill out only applicable sections. Fill out address only if different from client.

☐ Medicare ID number: _____ Medicare managed care? ☐ Yes ☐ No

☐ Medicaid ID number: _____ Medicaid managed care? ☐ Yes ☐ No

Name of managed-care organization: _____

☐ Primary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

☐ Secondary insurance company name: _____

Employer name: _____ Policy number: _____

Policyholder name: _____ Date of birth: _____

Group number: _____ Relationship to client: _____

Policyholder address : _____

City: _____ State: _____ Zip: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Section 5: Treating physician information

Note: Section 5 is new. Please fill out completely.

Name (first and last): _____ Email: _____

Practice name: _____

Practice address: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Secondary phone: _____ Extension: _____ ☐ Office ☐ Mobile

Fax: _____ License number: _____

NPI number: _____ Medicaid provider number (If applicable): _____

Section 6: Equipment recommendations

Note: Section 6 is new. Please fill out completely.

_____

_____

_____

_____

_____

Section 7: Signature

Note: Section 7 is new. Please review and sign the following acknowledgement.

I verify that all information contained herein is true to the best of my knowledge. I understand that the information provided will be used for the purpose of obtaining funding and hereby give permission to release this information as requested by the funding sources listed.

I understand that I may be able to rent or purchase the equipment that has been prescribed by my physician. The rental duration will be according to the manufacturers' policies. I understand that if my insurance coverage requires a capped rental, I will be subject to the terms and conditions of the capped rental program.

Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

Confidential Commercial Information

Patient Agreement and Consent

ACCOUNT NUMBER:	EMAIL:	CELL PHONE:	HOME PHONE:
PATIENT LAST NAME:	PATIENT FIRST NAME:		SUFFIX:
STREET ADDRESS:	CITY:	STATE:	ZIP:
TYPE OF EQUIPMENT: **DME & Supplies**			EFFECTIVE DATE:

REQUEST FOR PRODUCTS, EQUIPMENT, SUPPLIES, SERVICES

The undersigned, being the above-named patient ("Patient"), or on behalf of Patient, as his/her parent, legal guardian, legal representative or legally responsible party ("Undersigned") understands that by signing this Patient Agreement and Consent, the Undersigned desires to rent or purchase certain medical equipment, products, supplies, prescription drugs and/or associated services (collectively, to the extent applicable, the "Items") from Supplier and its affiliates ("SUPPLIER") (a list of affiliates can be found under Get to Know Us at: https://www.lincare.com/why-lincare/Get-to-Know-Us).

ACKNOWLEDGEMENT OF MEDICAL RESPONSIBILITY AND INFORMED CONSENT

The Undersigned understands that (1) Patient is under the supervision and control of an attending practitioner; (2) Patient's practitioner has prescribed the Items noted as part of Patient's treatment; (3) SUPPLIER's services do not include diagnostic, prescriptive or other like functions typically performed by licensed practitioners; and (4) Patient's practitioner is solely responsible for diagnosing and prescribing the Items or other therapies for Patient's condition and otherwise for controlling Patient's medical care. The Undersigned has been informed by Patient's practitioner of the possible increased risks associated with in-home care, including possible delays in receiving treatment for life threatening conditions as a result of being outside the hospital setting. The Undersigned has discussed his/her concerns with Patient's practitioner and has had all associated questions answered to his/her satisfaction.

ACKNOWLEDGEMENTS OF RECEIPT AND AGREEMENT TO CONTACT

The Undersigned acknowledges receipt of a copy of each of the following and/or receipt of a means to access a copy of each of the following: (1) the Medicare DMEPOS Supplier Statement; (2) SUPPLIER's Notice of Privacy Practices; (3) the Patient's Bill of Rights; and (4) Patient Responsibilities. These documents can also be found on SUPPLIER's website. The Undersigned understands and agrees that SUPPLIER, its affiliates and third parties acting on SUPPLIER's behalf may contact Undersigned or Patient, via text, call, automated call, artificial or recorded voice and/or email ("Contacts") at any of the telephone number(s) and/or email address specified hereon or as otherwise provided by the Undersigned for healthcare, accounting or other related purposes. The Undersigned understands and agrees that the frequency, time, quantity and length of Contacts shall be determined as may be necessary based on the subject of the communication. The Undersigned further understands that the agreement to contact via text, automated calls, and/or artificial or recorded voice calls is not a condition of service. The Undersigned confirms that the telephone number(s) (whether cell or residential) and/or email address provided hereon or otherwise, are true and correct and belong to the Undersigned. The Undersigned agrees to notify the SUPPLIER in writing in the event Undersigned's email address or telephone number(s) change.

CONSENT TO RELEASE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Undersigned authorizes (1) Patient's insurer(s) and any other third party payor(s) which provide Patient with coverage to disclose to SUPPLIER minimum necessary information to facilitate payment to SUPPLIER for items furnished Patient including, but not limited to (A) payment made by such payor(s) to Patient, the Undersigned or to any other person or entity for Items provided by SUPPLIER to Patient; and (B) the scope and extent of Patient's coverage from time to time; (2) all medical personnel involved in Patient's treatment to disclose to SUPPLIER any and all information concerning Patient's medical history and condition as it may relate to the Items or treatment provided to Patient by SUPPLIER; and (3) any holder of medical information about Patient (including SUPPLIER) to release to the Centers for Medicare & Medicaid Services (or any successor agency) and its agents, to any of Patient's third party payor(s) including, without limitation, Medicare, Medicaid, CHAMPUS, TRICARE or other public or private payors, and to SUPPLIER, any information needed (subject to "minimum necessary" requirements, as applicable) (A) to determine applicable benefits and qualification for reimbursement of Items furnished by SUPPLIER to Patient; (B) to process claims for Items provided by SUPPLIER to Patient; and/or (C) to conduct health care compliance and general business activities (including, without limitation, pre- and post-payment audits) and quality assurance and utilization reviews. The Undersigned hereby authorizes Patient's health care providers and payors to rely on this "Consent to Release of Health Information," without the need for a separate release authorization, to release the specified information for treatment, payment and health care operations purposes as contemplated herein. This consent shall not be effective to permit disclosures of information in cases where a HIPAA-compliant release authorization is required by law.

AGREEMENT TO PAY

The Undersigned agrees to pay for all Items provided by SUPPLIER to Patient. The monthly balance due will be that portion of SUPPLIER's applicable charges not paid by insurance or any other payor, including coinsurance, co-payment and deductible amounts, as well as amounts due for non-covered Items provided to Patient by SUPPLIER. The Undersigned agrees to pay the balance due in full upon receipt of an invoice from SUPPLIER. If prompt payment is not made, SUPPLIER may pursue its standard collection policy or other applicable remedies at SUPPLIER's sole discretion. **FOR CALIFORNIA RESIDENTS ONLY:** A holder of this medical debt contract is prohibited by Section 1785.27 of the California Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

CREDIT CHECK AUTHORIZATION

The Undersigned authorizes SUPPLIER (1) to verify any financial or payment information disclosed by Patient or the Undersigned and to perform a credit investigation for the purpose of extending credit for the purchase or rental of Items and (2) to answer any questions from other creditors about Patient's or the Undersigned's credit and account experience with SUPPLIER.

MISCELLANEOUS

The Undersigned certifies that the information provided to SUPPLIER under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is true and correct. Patient, if physically and mentally competent, must sign this Patient Agreement and Consent on his/her own behalf. If Patient cannot sign for himself/herself, the source of the Undersigned's authority to sign on behalf of Patient must be stated. This Patient Agreement and Consent is used in lieu of Patient's or his/her representative's signature on the "Request for Payment" CMS-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal health care program may, upon conviction, be subjected to fines and imprisonment under federal law. Penalties may also result from falsification or misrepresentation of other health insurance claims. The Undersigned agrees that this Patient Agreement and Consent may be executed with electronic signatures which shall have the same legal and binding effect as a written/manual signature. A copy of this Patient Agreement and Consent may be used in place of the original.

The Undersigned certifies that he/she (1) is the Patient or is legally authorized to execute this Patient Agreement and Consent and accept its terms and (2) has read the foregoing and understands and agrees to the terms hereof.

Patient, Legally Authorized Representative Signature: _____

Relationship/Authority to Sign (If not Patient): _____

Date: _____

Area Manager: GINA SINGER **Area Manager Telephone:** 877.893.5305

Company Representative First Name: _____ **Company Representative Last Name:** _____

Company Representative Email: _____ **Date / Time:** _____

Opt-In Written Consent for Marketing Communications

By signing and agreeing below (or by providing consent electronically), you consent to receive electronic marketing communications via e-mail, automated calls, pre-recorded or artificial voice and/or text messages from SUPPLIER and its affiliates (a list of SUPPLIER'S affiliates can be found under Get to Know Us at: https://www.lincare.com/why-lincare/Get-to-Know-Us) and parties acting on their behalf at the phone number(s) and email you provided. The purpose of this Consent is to allow SUPPLIER, its affiliates and parties acting on their behalf to send you marketing messages, including, but not limited to, those containing information about new products and services, programs and special offers. You acknowledge that these messages may include HIPAA-protected and other personal information. SUPPLIER cannot guarantee the security of any information, including HIPAA-protected or personal information, transmitted via SMS or email using a third party (such as Google, AOL, AT&T, Verizon and others). You understand: 1) You may obtain this HIPAA-protected or personal information via an alternative method; 2) Agreeing to this Consent is not a condition of purchasing any goods or services; 3) The frequency of messages will vary and message and data rates may apply; and 4) The acceptance or rejection of this Consent does not affect the ability of SUPPLIER and its affiliates to send you other categories of electronic messages/communications via e-mail, automated calls, pre-recorded or artificial voice and/or text messages that are otherwise allowed by agreement and/or without express written consent.

Patient/Authorized Representative Signature: _____ **Date:** _____

HIPAA MARKETING AUTHORIZATION

SUPPLIER is hereby authorized to use and disclose my contact information and order history to make marketing communications to me about products or services that I might be interested in. This Authorization will expire 15 months following the last date SUPPLIER furnished products and/or services, or at any time you choose to revoke this Authorization by calling _____. SUPPLIER may not condition your receipt of services or equipment on whether you choose to sign this Authorization. Disclosures for this purpose will only be made to SUPPLIER's contracted printers/mailing houses, not to manufacturer partners. I acknowledge that SUPPLIER may receive financial remuneration from an affiliate or manufacturer whose product or service is being marketed. By law, we are required to notify you that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and thus no longer protected by HIPAA. For the purposes of my consent to marketing communications, the most recently executed HIPAA Marketing Authorization controls.

Patient/Authorized Representative Signature: _____ **Date:** _____

Patient's Rights and Responsibilities

PATIENT'S BILL OF RIGHTS

SUPPLIER will function using the following guidelines while providing patient care. The patient/client has the right to:

1. Receive service without regard to race, creed, gender, age, handicap, sexual orientation, veteran status, or lifestyle.
2. Participate in decisions regarding his/her care.
3. Receive information in a manner in which he/she can understand and be able to give informed consent to the start of any procedure or treatment.
4. Be provided with information concerning those aspects of his/her condition related to the care provided by SUPPLIER or other agencies contracted by SUPPLIER.
5. Be informed of any responsibilities he/she may have in the care process.
6. Have care provided by qualified personnel who are knowledgeable to perform procedures at the level of care required.
7. Refuse treatment to the extent permitted by law and to be informed of the consequences of such action.
8. Be informed of the availability, upon request, of SUPPLIER policies and procedures.
9. Be informed, at admission, of the organization's charges and policies concerning payment for services.
10. Discuss problems and suggest changes regarding the services or staff without fear of discrimination.
11. Privacy concerning his/her records.
12. Expect and receive care in a timely manner, appropriate to his/her needs.
13. Choose his/her home care provider.
14. Formulate advance medical directives, which are legal documents that allow him/her to give direction for his/her future medical care.
15. Be free from any mental or physical abuse, neglect, or exploitation of any kind by staff.
16. Have his/her property treated with respect.

PATIENT'S RESPONSIBILITIES

As a home healthcare patient, you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies, infections, diseases, and other pertinent Items.
2. Assist in developing and maintaining a safe environment.
3. Inform SUPPLIER when you will not be able to keep a home care visit.
4. Participate in the development of and adherence to your home care plan of service/treatment.
5. Request further information concerning anything you do not understand.
6. Contact your physician whenever you notice any change in your condition.
7. Contact SUPPLIER whenever you have an equipment problem or if you change physicians.
8. Contact SUPPLIER whenever you have received a change in your home care prescription.
9. Contact SUPPLIER whenever you are to be hospitalized or receive services from a home health agency pursuant to a Medicare plan of care.
10. Give information regarding concerns and problems you have to SUPPLIER.
11. Ensure that the financial obligation for your equipment is fulfilled promptly.
12. Maintain and repair purchased equipment when equipment is no longer under warranty.
13. Follow equipment care procedures as outlined on Equipment Orientation Form.

SUPPLIER is a direct or indirect subsidiary of Lincare Holdings, Inc. Lincare Holdings, Inc. is owned by Linde North America Holdings Limited, a privately held company. If you feel that SUPPLIER has not respected your rights, we would ask that you please contact our area manager (shown on reverse side). It is the area manager's responsibility to review all formal complaints, and you will be entitled to a written response to your formal complaint. If feel that you have not received satisfactory resolution, you may contact CHAP at 800.656.9656, extension 242. I have reviewed and understand the Patient's Bill of Rights and my Patient/Client Responsibilities.

ASSIGNMENT OF BENEFITS

ACCOUNT NUMBER:			
PATIENT LAST NAME:	PATIENT FIRST NAME:		SUFFIX:
STREET ADDRESS:	CITY:	STATE:	ZIP:
TYPE OF EQUIPMENT: **DME & Supplies**			EFFECTIVE DATE:

The undersigned, as or on behalf of Patient, requests that payment of authorized benefits be made to Supplier and its affiliates ("SUPPLIER") and authorizes SUPPLIER to collect directly all public and private insurance coverage benefits due, for any Items (as defined in the SUPPLIER'S Patient Agreement and Consent) furnished to Patient by SUPPLIER. In the event benefit payments due SUPPLIER are paid directly to Patient or the undersigned, the payee shall immediately, and without request from SUPPLIER, endorse and remit to SUPPLIER all such benefit payment checks. On assigned Medicare claims, SUPPLIER shall accept the applicable Medicare allowable amount (including deductibles and co-payment/co-insurance) in full for covered Items. The undersigned certifies that the information provided to SUPPLIER by or on behalf of Patient under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is true and correct. Patient, if physically and mentally competent, must sign this Assignment of Benefits on his/her own behalf. If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This Assignment of Benefits is used in lieu of Patient's or his/her representative's signature on the "Request for Payment" CMS-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a claim under Medicare or any other federal health care program may, upon conviction, be subjected to fines and imprisonment under federal law. Penalties may also result from falsification or misrepresentation of other health insurance claims. A copy of this Authorization of Benefits may be used in place of the original.

Signature of Patient, Guardian or Representative **Date**

If not signed by Patient, below identify the person signing:

Print Name **Relationship to Patient**

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Apple ID creation and usage policy.

Customer ID (internal use only): _____

Client name: _____ Date of birth: _____

Lincare AAC® may create an Apple ID to facilitate distribution of authorized apps. All parties must agree to the following:

- The assigned Apple ID is only for the use of apps authorized by Lincare AAC.
- iCloud storage is authorized solely for the purpose of backing up software customization.
- The assigned Apple ID requires a trusted phone number which must be selected in the contact information section of the client information.

I have read, understand, and agree to the Lincare AAC Apple ID creation and usage policy.
Client, parent, legal guardian, Power of Attorney, or legal representative signature:

Signature: _____ Date: _____

Printed name: _____ Relationship to client: _____

Speech-generating device DME prescription.

Order date: _____

Client information

Name (first and last): _____ Date of birth: _____

Insurance ID: _____

Street address: _____

City: _____ State: _____ Zip: _____

Clinical diagnosis

Medical diagnosis (Include ICD-10): _____

Communication diagnosis (Include ICD-10): _____

Prognosis with speech-generating device: ☐ Good ☐ Other: _____

Length of need: ☐ Lifetime ☐ Other: _____

Date of last practitioner visit: _____

Equipment prescribed

_____

_____

_____

_____

Physician information

I have reviewed a copy and agree with the speech-language pathologist's completed Augmentative Communication Evaluation for the above patient. The prescribed device and accessories are necessary to achieve the functional communication goals for this patient as noted in the SLP's treatment plan. I certify that a face-to-face examination for the patient's speech impairment has been documented in the patient record.

I do not have a financial relationship with, nor will I receive any other gain from, the manufacturer of the recommended device.

Practitioner's name: _____ Phone: _____

Practice address: _____ Fax: _____

City: _____ State: _____ Zip: _____

License number: _____ Issuing state: _____ NPI number: _____

Physician's signature: _____ Date: _____

Client name: _____ Date of birth: _____

Customer ID (internal use only): _____

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SGD evaluation criteria.

Per Centers for Medicare & Medicaid Services (CMS) regulations

A speech-generating device (SGD) (E2500 - E2510) is covered when all of the following criteria (1-7) are met:

1. Prior to the delivery of the SGD, the patient has had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP). The formal, written evaluation must include, at a minimum, the following elements:
   a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;
   b. An assessment of whether the individual's daily communication needs could be met using other natural modes of communication;
   c. A description of the functional communication goals expected to be achieved and treatment options;
   d. Rationale for selection of a specific device and any accessories;
   e. Demonstration that the patient possesses a treatment plan that includes a training schedule for the selected device;
   f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate;
   g. For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the patient of the upgrade compared to the initially provided SGD.
2. The patient's medical condition is one resulting in a severe expressive speech impairment.
3. The patient's speaking needs cannot be met using natural communication methods.
4. Other forms of treatment have been considered and ruled out.
5. The patient's speech impairment will benefit from the device ordered.
6. A copy of the SLP's written evaluation and recommendation have been forwarded to the patient's treating physician prior to ordering the device.
7. The SLP performing the patient evaluation may not be an employee of or have a financial relationship with the supplier of the SGD.

If one or more of the SGD coverage criteria 1-7 is not met, the SGD will be denied as not reasonable and necessary.

Codes E2500 – E2510 perform the same essential function; speech generation. Therefore, claims for more than one SGD will be denied as not reasonable and necessary.

Accessories (E2599) for E2500 – E2510 are covered if the basic coverage criteria (1-7) for the base device are met and the reasonable and necessary criteria for each accessory are clearly documented in the formal evaluation by the SLP.

Notice of privacy practices.

Effective November 2020

Client name: _____ Customer ID (internal use only): _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices describes how we (including other healthcare providers affiliated with us) may use and release protected health information about you that we maintain.

Permitted and Required Disclosures of Protected Health Information:

Treatment, Payment and Healthcare Operations. As one of your healthcare providers, we may use and disclose protected heath information ("PHI") about you for treatment, payment and healthcare operations without your authorization. Some examples of these types of uses/ disclosures are:

- **Treatment.** We may use or disclose PHI about you to provide your prescribed products, equipment or services. We may consult and coordinate with your physician. We may remind you of your medication or supply refills and scheduled visits/appointments. We may provide you information about treatment alternatives or other health benefits and services that may be of interest to you through newsletters or other means. We may also disclose your PHI to other healthcare providers (such as physicians and pharmacies) involved in your treatment.
- **Payment.** We may use or disclose your PHI to bill and collect payment for the products, equipment or services we provide you. We may contact your insurer or payor to obtain eligibility and coverage information. We may also disclose your PHI to health plans, healthcare clearinghouses or other healthcare providers involved in your care for their payment activities.
- **Healthcare Operations.** We may also use or disclose your PHI for quality assessment activities, evaluation of our employees' performance, business planning and development, and management and general administrative purposes. We may disclose your PHI to health plans or other healthcare providers for their quality assessment, employee evaluation or healthcare compliance activities.

We also engage consultants and contractors to perform certain services for us. When the nature of these services involves PHI disclosure, the consultants/contractors are required to appropriately safeguard the PHI they receive.

Other Permitted and Required Uses and Disclosures:

We may use or disclose your PHI for the following reasons without your consent:

- **Persons Involved in Care/Payment**. We may disclose relevant parts of your PHI to family members or other persons involved in your care and its payment. We may notify such persons or public or private entities involved in disaster relief efforts of your location, general condition or death.
- **Limited Marketing Purposes.** From time to time, we may also provide promotional items of nominal value or marketing information communicated to you in person (face-to-face).
- **Health Oversight Activities.** We may disclose parts of your PHI to regulatory authorities for purposes of monitoring the healthcare system and compliance with civil rights laws and government regulations and healthcare program requirements.

- **Health or Safety.** We may use or disclose parts of your PHI if we believe it is necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of another person or the public. In certain circumstances, this may include disclosing parts of your PHI to local utility companies or emergency services so that they may provide appropriate assistance in the event of an emergency or power outage.
- **Abuse, Neglect or Domestic Violence.** We may disclose parts of your PHI to appropriate governmental agencies if we believe you may be a victim of abuse, neglect or domestic violence and such disclosure is authorized by applicable law or regulation.
- **Public Health Activities.** We may disclose parts of your PHI to public health authorities for purposes of controlling disease, injury or disability. We may also release parts of your PHI to the Food and Drug Administration to report adverse events, track products, enable recalls, conduct post-marketing surveillance and other activities in connection with its regulation of the quality, safety and effectiveness of certain products or activities.
- **Research.** We may use or disclose your PHI to perform or facilitate research when permitted by federal and state law. This may include preparing for research or telling you about research studies in which you might be interested.
- **De-Identified Information.** We may use or disclose parts of your PHI that do not personally identify you or reveal who you are.
- **Workers Compensation.** To the extent authorized by applicable law, we may disclose your PHI to workers compensation or similar programs that provide benefits for work-related injuries or illnesses.
- **Correctional Institutions.** If you are incarcerated or otherwise in the custody of law enforcement officials, we may disclose certain of your PHI to correctional institution or facility or its authorized personnel.
- **Legal Proceedings.** We may disclose parts of your PHI in any judicial or administrative proceeding pursuant to court order or if we meet other legal requirements.
- **Law Enforcement.** We may disclose parts of your PHI to locate or identify a suspect, fugitive, material witness or missing person; to comply with laws such as those requiring reporting of certain injuries or death or to report certain crimes.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose parts of your PHI to coroners and medical examiners for identification purposes, to determine cause of death or as otherwise required by law. We may also disclose, consistent with applicable law, parts of your PHI to funeral directors to permit them to carry out their duties.
- **Organ or Tissue Donation Purposes.** We may disclose parts of your PHI to organ procurement organizations or other entities to facilitate organ or tissue procurement, banking or transplantation.
- **Specialized Government Functions.** Under certain circumstances, we may disclose parts of your PHI to Armed Forces personnel and to Department of State and other federal officials in connection with specialized governmental functions (including military missions, national security and protective services).
- **Governmental Agencies.** We may disclose parts of your PHI to governmental authorities entitled to receive such information, including the Secretary of Health and Human Services.
- **Required or Permitted by Law.** We may disclose parts of your PHI in other situations not mentioned above when required or permitted by law.

Other Disclosures:

Uses of PHI for marketing purposes and disclosures that constitute the sale of PHI require your written authorization. Other uses and disclosures of your PHI not described previously will be made only with your written authorization.

Your Rights:

The following is a statement of your rights regarding your PHI and a brief description of how you may exercise these rights:

- **Access.** You have the right to inspect and copy the PHI we maintain about you except for: psychotherapy notes, information compiled in anticipation of a legal proceeding or other PHI to which your access is limited by federal law. Requests to inspect and copy records must be in writing directed to our Privacy Officer and provide specific information to assist us in fulfilling your request. We may charge a reasonable fee for copying and mailing copies. If we deny your request for access, under most circumstances, you have the right to have the denial reviewed. Please contact our Privacy Officer if you have questions concerning your right to inspect and copy your records.
- **Confidential Communications.** You have the right to request that PHI be sent to you by alternate means or at alternative locations. For instance, you can ask that we send mail to a post office box rather than to your home address. We will accommodate all reasonable requests. Please make this request in writing to our Privacy Officer.
- **Restrictions.** You have the right to request restrictions on how we use or disclose your PHI for our treatment, payment and healthcare operations activities. You also have the right to request that we not release any part of your PHI to family members or others who may be involved in your care. Your request must be in writing to our Privacy Officer and must specify what parts of your PHI you do not want released and to whom you do not want it released. However, you have the right to restrict certain disclosures of PHI to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains to a service for which you have paid out-of-pocket in full.

  We are not required to agree to your request and only our Privacy Officer is authorized to agree to such requests. If we agree to your request, we will abide by the restriction unless the restricted PHI is needed to provide you emergency treatment.
- **Amendment**. You have the right to request that we amend the PHI we maintain about you. Requests for amendment must be in writing directed to our Privacy Officer and provide a reason to support your request amendment. If we deny your request for amendment, you may file a written statement of disagreement with our Privacy Officer and we will include it in your PHI when used and disclosed.
- **Breach.** You have the right to or will receive notifications of breaches of your unsecured PHI.
- **Accounting.** You have the right to receive an accounting of certain disclosures of PHI made by us. Your request for accounting must be in writing directed to our Privacy Officer and must not request an accounting for more than six years. Certain disclosures are not required to be included in the accounting including: disclosures for our treatment, payment and healthcare operations activities, incidental disclosures, disclosures for national security, disclosures to correctional institutions, certain disclosures of PHI without personally identifying information; and any disclosures made prior to April 14, 2003.
- **Copy of Notice of Privacy Practices.** You have the right to receive a paper copy of our Notice of Privacy Practices even if you agreed to receive our Notice of Privacy Practices electronically. You may obtain a copy from your local service center or by contacting our Privacy Officer and requesting a copy by mail.

Our Responsibilities:

We are required by law to maintain the privacy of protected health information and to provide you notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of our Notice of Privacy Practices or applicable state laws which provide for more restrictions on the use and disclosure of your PHI.

Changes to Notice of Privacy Practices:

We may change the terms of our Notice of Privacy Practices at any time. The new Notice of Privacy Practices will apply to all PHI that we maintain on or after the effective date of the new Notice of Privacy Practices. Upon request to your local service center, we will give you a copy of a new Notice of Privacy Practices. You may also obtain this information by calling our Privacy Officer and requesting a copy by mail.

Complaints:

If you believe your privacy rights have been violated, you may lodge a complaint by contacting our Privacy Officer. You may also complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Additional Information:

If you need additional information about our Privacy Practices, please contact our Privacy Officer at:

Privacy Officer

19387 U.S. 19 North

Clearwater, FL 33764

HIPAA Hotline Telephone: 800-284-2006, ext. 10028.

Patient, Legally Authorized Representative Signature: _____

Relationship/Authority to Sign (If not Patient): _____

Date: _____

Area Manager: GINA SINGER **Area Manager Telephone:** 877.893.5305

Company Representative First Name: _____ **Company Representative Last Name:** _____

Company Representative Email: _____ **Date / Time:** _____

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Medicare DMEPOS supplier standards.

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.

Warranty and returns information.

Warranty

Lincare AAC® Lincare AAC® Expression Series devices come with a three-year limited warranty which begins on the date of device delivery to the user. Expression Series devices are protected with a three-year hardware warranty. Lincare AAC will honor all other manufacturer's warranties under applicable state law. Accessories (e.g., switches, keyguards, mounts, specialty cases) will follow the warranties of their respective manufacturers. Any replaced component will carry the balance of the warranty period. You will not be responsible for payment of repair or service for your equipment supplied by Lincare AAC during the warranty period. Guidelines for device replacement services are identified below:

a) Under this warranty, Lincare AAC will provide two (2) major repairs or replacement within the first two (2) years of ownership. Major repairs include: damaged screen, water damage, and proven battery failure. Lincare AAC will provide up to three (3) minor replacements over the course of the three-year warranty. Minor repairs include replacement speaker, shoulder strap, screen protector, and carry bag. One (1) case replacement with the issued Lincare AAC case will be honored within the three (3) year warranty.

b) If a case replacement is needed, the device must be in the original case when it is submitted for replacement. While under warranty, if it is deemed necessary that the user requires a different or specialized case (not a case that is one of our current case offerings), this must be pursued through the user's insurance provider(s).

c) If an unapproved Apple ID password is used on a device, the three-year warranty will be considered void.

d) Any and all warranty requests that require the speech generating device to be sent in for repair, must be sent with the device in it's original case.

If delivered item is deemed to be defective or does not meet your needs, Lincare AAC will accept the return or exchange of the item within 30 days of the device receipt. All products must be in new, unused condition to honor this service. If the product is not in this condition, restocking fees may apply. Some exceptions may apply for custom-build products, software, or special-ordered items that are non-refundable, as well as indicated products. Please contact Lincare AAC at 877.893.5305 for inquiries about a return or to obtain a return authorization number.

Obtaining warranty services

If a Lincare AAC device requires warranty service, please contact us at 877.893.5305. You will be provided with a device repair form to describe the problem, as well as a shipping label to ship the device back to Lincare AAC for repair. Once the device is repaired, the device will be shipped back to you.

Returns

Lincare AAC offers a 30-day money-back guarantee if our products do not meet your needs or expectations. Products must be in new and unused condition to honor this service; if not, restocking fees may apply. Some exceptions may exist for custom-built products, software, or special-ordered items are non-refundable, as well as indicated products.

Please contact Lincare AAC at 877.893.5305 for inquiries about a return, or to obtain a return authorization number (RT).

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