



Clinics Can Help Application Form

Please print this form, fill it out, and bring it with you when you come to our West Palm Beach office.

Client Name	Client #(Office use only)
Address	Date
City State Zip	Phone ()
Who referred you to Clinics Can Help?	Date of Birth of Client / /
Email Address	Ethnicity (optional)
Name of Person Responsible for Equipment	Relationship to Client
Address	Home Phone ()
City State Zip	Work Phone ()

Do you have health insurance/Medicare/Medicaid? YES NO

Have you already applied for assistance for the equipment? YES NO

If denied by insurance/Medicare/Medicaid, what was the reason? _____

How long will you need the equipment? _____

Equipment on Loan (to be filled out by CCH)

I acknowledge that the above-identified equipment was inspected by me, or my advocate, and at the time I received the equipment it was clean and in good condition. I agree that I will return the equipment in the same condition when my (or my child's) present physical need no longer exists. I will not permit this equipment to be transferred to another person under any circumstances, and while this equipment is in my possession, I will notify you of any change of address for me. I will not take this equipment out of the area served by Clinics Can Help. I hereby release and hold harmless Clinics Can Help, its members, agents, or employees from any claim by me, or any person acting for me or on my behalf for any loss, expense, or damage, including but not limited to general, specific, incidental, or consequential damages, of any kind or nature whatsoever arising from this equipment or its use. I agree that Clinics Can Help, its members, agents, or employees have made no representation of any kind whatsoever express or implied, to me with regard to the condition of the equipment provided or as to the use to which the equipment is to be put. I also give Clinics Can Help permission to take my photo and to use it in any and all promotional venues.

CPAP/NEBULIZER RIDER: I acknowledge that I am under the care of a physician and will not use this equipment without receipt of instructions on its use and care from my health care provider. _____ **(Initials)**

Signature of Client/Advocate _____ Date _____

**Please return equipment to:
Clinics Can Help 1550 Latham Rd Unit #10 West Palm Beach FL 33409 (561)640-2995**

One Copy of this form to recipient of equipment.
One copy of this form for CCH files.

Form revised Sept 2011