American Sleep Apnea Association

CPAP ASSISTANCE PROGRAM

● PO Box 1072, Tracy, MN 56175 ● Telephone: 888-293-3650 ● Fax 888-293-3650

● www.sleephealth.org ● manager@sleephealth.org ●

INSTRUCTIONS: Complete this form and fax to 888-293-3650 or email manager@sleephealth.org, include a copy of your prescription with the prescribed pressure settings needed. **Due to inventory levels being low our office will contact you prior to shipping to process the program fee. Do not submit your payment with this application.**

We currently have a waiting list for CPAP devices. To get on the list, please complete this application and submit a copy of your CPAP prescription with pressure settings listed. This will allow us to verify your eligibility and add you to the list for the next available machine. Once a device is ready for you, we will contact you by email with instructions for paying your $200.00 program fee. You must contact us within 48 hours of notification to pay or make payment arrangements to secure your machine. The **$200 program fee per equipment package must be paid prior to shipping.**

Shipments to cities in the Continental US are included in the program fee and sent via USPS. If you are located in Hawaii or Alaska, there is an extra $20 charge for shipment through the US Postal Service.

By submitting this application, you hereby authorize the American Sleep Apnea Association (ASAA) to dispense the prescribed equipment package that you request below. The equipment package consists of a gently used continuous positive air pressure machine, tubing, filter, and carrying case. A full-face mask is included, and you may request a different style mask, but your request may not be guaranteed. Please select a mask style and size on the form and we will include it if we have your choice in our inventory. (Mask includes frame, cushion and headgear.)

First Name ________________________________ Last Name ________________________________
Email ____ Phone _____________________________
Mailing/Shipping Address:
Street Address ____

City ______________________________________State _________Zip ______________________

Choose equipment package:

☐ CPAP ☐ AUTO CPAP ☐ BiLevel

Choose Mask Size and Style: Nasal Masks Full Face Nasal Pillow

Small Medium Large

Please be sure to complete and return both pages of this application.

As a participant in the programs available through the American Sleep Apnea Association (ASAA), please provide the following Information:

How many **nights** a week are you using CPAP now: 0-2 3-5 6 –7

How many **hours per night** are you using CPAP now: 0-3 4-7 8 or More

As a non-profit, 501C3 organization, we often work with research institutions and other healthcare programs. Please complete the questions below, these are optional, and only for reporting purposes. This will not affect your program status.

Gender: Male Female Transgender Male Transgender Female Non-Binary Other

Date of Birth: _____________

Ethnicity: American Indian or Alaska Native Asian Black or African American Hispanic or Latino White

Native Hawaiian or Other Pacific Islander

Household Income: $0-30,000 $30,001- 45,000 $45,001-60,000 $60,001-75,000 $75,001-90,000 over$90,000

Why are you interested in the CPAP Assistance Program?

I don't have health insurance It's too expensive through my health insurance My insurance doesn't cover it

I'm currently unemployed Other: __________

Where did you hear about the CAP Program? From my doctor From a friend/relative ASAA Newsletter

ASAA Social media (Facebook, Twitter or IG) Sleephealth.org Facebook or Google Ad Other: __________

Patient Acknowledgement: I acknowledge that the equipment package is offered "as is" without any warranty or technical support from the manufacturer. I understand that the machine may be gently used. I understand that ASAA is neither a DME Supplier nor a DME Provider. I understand that ASAA does provide a 30-day warranty in the event the device is damaged during shipment or has a mechanical failure and will replace the machine for free. I understand and acknowledge that ASAA is not responsible for the medical device, my use of it, its suitability for my medical condition, or its set-up, maintenance, supplies or repairs. I hereby release from liability and waive any right to sue ASAA, their officers, directors, employees, agents and contractors, from any and all claims, including claims of negligence or physical harm or injury.

I ACKNOWLEDGE AND AGREE THAT ASAA MAKES NO WARRANTIES OR REPRESENTATIONS, EXPRESS OR IMPLIED, TO ME OR ANY OTHER PERSON WITH RESPECT TO THE EQUIPMENT PACKAGE. ASAA SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES INCLUDING, WITHOUT LIMITATION, THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE AND NON-INFRINGEMENT.

I agree to the patient acknowledgement above.

Signature: ____________________________________Date: __________________________