

## CPAP Assistance Program PAP Machine Application

### INSTRUCTIONS

Complete application in full and provide a copy of your prescription with the prescribed pressure settings needed. Completed applications and prescriptions can be faxed to 888-293-3650, emailed to [manager@sleephealth.org](mailto:manager@sleephealth.org), or mailed to WSCN, PO Box 1072, Tracy, MN 56175.

**Due to our current 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 Wellness, Sleep & Circadian Network (WSCN) 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.)

### Patient information:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

### Shipping address:

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Choose Equipment Package: *(Select one)*

CPAP     AUTO CPAP     BiLevel

### Mask Style: *(Select one)*

\*Full-face     Nasal     Pillow    \*\*Comment/Request \_\_\_\_\_

### Mask Size:*(Select one)*

Small     Medium     Large

NOTE: The WSCN Programs are provided through donations that have been received; we do not order masks or supplies through a manufacturer. Each package will include a \*full-face mask in the size selected.

\*\*Special requests may be noted above of the brand, model and/or style preferred, but **are not guaranteed**

As a participant in the programs available through the Wellness, Sleep & Circadian Network (WSCN), please provide the following Information: *(Select one)*

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 questions are for reporting purposes. This will not affect your program status.

**Gender:** *(Select one)*

- Male     Female     Transgender Male     Transgender Female     Non-Binary    Other: \_\_\_\_\_

**Ethnicity:** *(Select all that apply)*

- American Indian or Alaska Native     Asian     Black or African American     Hispanic or Latino  
 White     Native Hawaiian or Other Pacific Islander

**Household Income:** *(Select one)*

- \$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?** *(Select all that apply)*

- I don't have insurance     Too expensive through insurance     Insurance doesn't cover it  
 I'm currently unemployed     Other \_\_\_\_\_

**Where did you hear about the CPAP Program?** *(Select all that apply)*

- From my doctor     From a friend/relative     Social media (Facebook, X, or IG)     Sleephealth.org  
 WSCN Newsletter     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 WSCN is neither a DME Supplier nor a DME Provider. I understand that WSCN 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 WSCN 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 WSCN, 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 WSCN MAKES NO WARRANTIES OR REPRESENTATIONS, EXPRESS OR IMPLIED, TO ME OR ANY OTHER PERSON WITH RESPECT TO THE EQUIPMENT PACKAGE. WSCN 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 acknowledgment above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_