

CPAP Assistance Program

CPAP MASK/Yearly Supply Program APPLICATION

INSTRUCTIONS

Complete application in full, provide a copy of your prescription and make the program Fee. Completed applications and prescriptions can be faxed to 888-293-3650, emailed to manager@sleephealth.org or mailed to WSCN- PO BOX 1072, Tracy, MN 56175. Program fees can be made in the form of certified funds (money order or certified check, no personal checks) Payable to WSCN and mailed to PO Box 1072, Tracy, MN 56175. You can also call 888-293-3650 to process with debit/credit card over the phone. All prices include USPS First Class shipping (If you are in Hawaii or Alaska, there is an extra \$5.00 charge for shipment through the US Postal Service.) The program fee helps to defray program costs and allows us to help others.

Shipments will NOT go out until we receive the application, the prescription and the program fee.

Patient information:

First Name _____ Last Name _____

Email _____ Phone _____

Shipping address:

Street Address _____

City _____ State _____ Zip Code _____

Mask Package: *(Select one)*

- 1 mask - \$25.00 Program Fee 2 masks - \$45.00 Program Fee 3 masks - \$60.00 Program Fee
 Yearly Supply Program - \$100.00 Program fee *(includes 4 masks, 4 filters and 2 universal tubes all in one shipment)*
 Other _____

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

Machine Make/Model *(Required for Yearly Supply Program packages): I have a...*

Philips Respironics: Dreamstation Dreamstation 2

ResMed: S9 Aircurve S10 Airsense S10 AirCurve 11 Other: _____

As a participant in the programs available through the Wellness, Sleep & Circadian Network (WSCN), 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

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

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

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) WSCN Website
 WSCN Newsletter Facebook or Google Ad Other: _____

Why are you using the CAP Program* *(Select all that apply)*

I don't have insurance Too expensive through insurance Insurance doesn't cover it
 I'm currently unemployed Other: _____

Patient Acknowledgment

I hereby release from liability and waive any right to sue the Wellness, Sleep & Circadian Network (WSCN), their officers, directors, employees, agents, and contractors, from any and all claims, including claims of negligence or physical harm or injury. WSCN CPAP Program is not covered by medical insurance providers, nor will the organization bill any insurance company. The low program fee for your PAP equipment assures that the program can be sustained for those without medical insurance coverage or those experiencing financial hardships.

WSCN provides no instruction on mask use, mask fit nor follow up care. If you require these services, follow up with your healthcare provider. By submitting this application, you hereby authorize WSCN to dispense the prescribed mask or masks that you requested above. The mask is offered, new and factory sealed "as is" and without warranty. If masks are damaged in shipment, please notify us promptly and we will replace them. No returns on opened masks.

By signing this Patient Acknowledgment, you confirm you have read and agree to move forward with shipping of a full-face mask if your specific request is not available.

I ACKNOWLEDGE AND AGREE THAT THE 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.

Signature: _____

Date: _____