sleepapnea.org
American Sleep Apnea Association

CPAP ASSISTANCE PROGRAM

● 524 Craig Ave., Tracy, MN 56175 ● Telephone: 888-293-3650 ● Fax 888-293-3650

● www.sleepapnea.org ● manager@sleepapnea.org ●

INSTRUCTIONS: Complete this form and fax to 888-293-3650, please make sure you pay the program fee and send your prescription with continuous positive airway pressure (CPAP) settings.

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 continuous positive air pressure machine, tubing, filter, carrying case, and patient and/or clinician manuals. **No humidifier is provided in the CAP equipment package**.

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 if we have your choice in our inventory.

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

The equipment package is offered **"as is" and without warranty or technical support from the manufacturer.** The 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. The ASAA provides no CPAP set up, no instruction on device use, mask fit nor follow up care. If you require these services, we will ship to the office or agency you direct below who will provide these services. Otherwise, authorization to ship directly to the patient may be indicated below. The **$100 program fee per equipment package must be paid prior to shipping.** This defrays program costs and allows us to help others.

FirstName _____ Last Name _____

Email _____ Phone _____

Mailing/Shipping Address:

Street Address _____

City _____State _____Zip _____

Choose equipment package (**BiLevel's are not available**)

☐ CPAP ☐ AUTO CPAP

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 we will include it if we have your choice in our inventory.

Mask Size: ☐ Small ☐ Medium ☐ Large ☐ No Mask

Mask Style ☐ Nasal Mask ☐ Nasal Pillow

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I understand and acknowledge that the ASAA is not responsible for the medical device, my use of it, its suitability for my medical condition, or its maintenance, supplies or repairs.

I hereby release from liability and waive any right to sue the 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 THE 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: _____

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 **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

Where did you hear about the CAP Program? From my doctor From a friend/relative ASAA Newsletter
ASAA Social media (Facebook, Twitter or IG) Sleepapnea.org Facebook or Google Ad Other: _____