Dear Healthcare Provider:

One of your patients is requesting donated medical equipment from the American Sleep Apnea Association (A.S.A.A.) CPAP Assistance Program (CAP). The donation program provides medical equipment to individuals who find themselves in extreme financial hardship. Although we do not require financial statements, proof of disability or unemployment etc., we do ask that the clinician or social worker make a good faith effort to assist us in establishing patient need.

If you feel that your patient is a good candidate for a donation of CPAP/APAP/BiLevel equipment, please authorize the CAP administrator to dispense these items by providing a clinician signature by completing the following brief authorization form. The equipment package MUST be shipped to the clinician or agency you identify that will take care of the fitting of the equipment, instruction of the patient on its use, and continued availability to the patient for follow-up as needed.

To defray the cost of shipping and handling, beneficiaries are required to make a $100 CAP Program Application Fee to the American Sleep Apnea Association prior to shipping the medical equipment.

Mark Seager, RRT, Minnesota License Number 2958, Member National Board of Respiratory Care supervises the dispensing of all donation equipment.

Incomplete Applications Cannot Be Processed

Required signatures
Clinician signatures, as specified, are required on the Equipment Package Request Form (page 4) and the Clinician Waiver and release of Claims Form (page 5). Patient signature, as specified, is requited on the Patient Waiver and release of Claims Form (page 5).

Required application pages to be submitted
CAP Program Request Form – Page 3
Equipment Package Request Form – Page 4
Waiver and Release of Claims Form – Page 5

Respectfully,

Tracy R. Nasca, Executive Director
American Sleep Apnea Association

Revised: 09/2015
CAP Application Fee Information Page

The $100.00 program application fee can be paid online via credit/debit card or standard mail via money order. **Please note we do NOT accept personal checks.**

**ONLINE**

Visit our website [www.sleepapna.org](http://www.sleepapna.org)

Click on [Learn About the CPAP Assistance Program](http://www.sleepapna.org)

Click on the, ‘I NEED A CPAP’ button

[**I NEED A CPAP**](http://www.sleepapna.org)

Print the CAP application form. A licensed physician must complete the application on behalf of the patient. The patient is required to sign/witness the Claims & Waiver Form which is included in the printable application form.

[**CAP Application Form**](http://www.sleepapna.org)

Follow the CAP Program Application Fee link

[**CAP Program Application Fee**](http://www.sleepapna.org)

In the comment box please include the patient’s name for which you are paying

**STANDARD MAIL**

Please make a certified money order payable to the “American Sleep Apnea Association”

In the memo write: “CAP Application Fee and include patient name”

**Mail To:**

A.S.A.A- CAP  
117 3rd Street  
Tracy, MN 56175

Clinicin to fax completed application to 888-293-3650

**OR**

Scan and email completed application to manager@donatedcpap.org
Clinician Information

Date of Application: _____/_____/_______

Clinician License/NPID #: ________________________________

Prescribing Clinician Name: ________________________________________________________________

Clinician Full Address: ___________________________________________________________________
____________________________________________________________

Clinician Office/Clinic Phone Number: ______________________________________________________

Clinician Email Address: ________________________________________________________________
(Email address is required to receive UPS Tracking Information of shipped equipment)

SHIPPING INFORMATION (REQUIRED) - NOTE: WE CANNOT SHIP TO PATIENTS RESIDENCE

Clinician or agency to where the equipment is to be shipped: _________________________________

Department, c/o, etc.: _________________________________

Clinician/Agency Address (include suite, unit, building, floor, etc.):
_____________________________________________________________________________________
_____________________________________________________________________________________

Clinician/Agency Phone Number: __________________________________________________________

Patient Information

Patient Name: __________________________________________

Patient Date of Birth: _____/_____/_______  Patient Gender:  □ Male  □ Female

Patient Full Address: __________________________________________
_____________________________________________________________________________________

Patient Phone #: ________________________________

Patient Email Address: __________________________________
(Email address is required to receive UPS Tracking Information of shipped equipment)
Equipment Package Request Form

Equipment packages include: Machine, Mask, Tubing, Filter and Carrying Case. Requests for specific device brands are not guaranteed. Comparable machines and masks will ship as inventory allows.

WE DO NOT PROVIDE HUMIDIFICATION SYSTEMS. PATIENTS WILL BE RESPONSIBLE FOR ACQUIRING THEIR OWN HUMIDIFICATION SYSTEMS AND ONGOING RESUPPLIES.

Patient Name: __________________________________________

Clinician please check the following that apply and specify pressure requirements:

_____ CPAP Equipment Package - Pressure setting in cwp: ______

_____ APAP Equipment Package - Pressure Range in cwp Min: ______ Max: ______

_____ BiLevel Equipment Package - Inspiration Pressure in cwp: ______ Exhalation Pressure in cwp: ______

ASV Adaptive Servo Ventilation BiLevel not available

Please choose mask size and style carefully, we send what you check and cannot resend another mask.

<table>
<thead>
<tr>
<th>Mask Size:</th>
<th>Style:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ no mask</td>
<td>□ full face*</td>
</tr>
<tr>
<td>□ small</td>
<td>□ nasal mask</td>
</tr>
<tr>
<td>□ medium</td>
<td>□ nasal pillow</td>
</tr>
<tr>
<td>□ large</td>
<td></td>
</tr>
</tbody>
</table>

*When full face masks are not available, nasal mask and chin strap will be sent.

Additional Comments or Instructions (i.e. specific mask brand, device comfort settings for ramp or EPR or CFlex etc.)

Please ensure the patient is familiar with their equipment, knows how to turn machine on and off and have patient put mask on and confirm patient knows how to adjust mask.

Clinician Signature: ________________________________________________
Waiver and Release of Claims Form

Clinician Waiver and Release of Claims

In consideration of my patient, ____________________________________________________________, being accepted
to participate in the CPAP Assistance Program (CAP) of the A.S.A.A. and the receipt of a
CPAP/APAP/BiLevel Equipment Package (The Package), I, __________________________________________, hereby
release from liability and waive any right to sue the A.S.A.A., their officers, directors, employees, agents and contractors,
from any all claims, including claims of negligence or physical harm or injury (1) related in any way to The Package or
my patient’s use of The Package provided; or (2) otherwise related to my patient’s participation in the CPAP Assistance
Program.

I understand and acknowledge that the A.S.A.A. is not responsible for the CPAP/APAP/BiLevel device, its suitability for
my patient’s medical condition, or its maintenance, supplies or repairs. I understand that no warranty is being provided
with the CPAP/APAP/BiLevel Equipment Package.

___________________________________________  __________________________________________
Clinician Signature                            Date

Patient Waiver and Release of Claims

In consideration of being allowed to participate in the CPAP Assistance Program (CAP) of the A.S.A.A. and the receipt of
a CPAP/APAP/BiLevel Equipment Package (The Package), I, __________________________________________. hereby release
from liability and waive any right to sue the A.S.A.A., their officers, directors, employees, agents and contractors, from
any all claims, including claims of negligence or physical harm or injury (1) related in any way to The Package or my use
of The Package provided to me; or (2) otherwise related to my participation in the CPAP Assistance Program.

I understand and acknowledge that the A.S.A.A. is not responsible for the CPAP/APAP/BiLevel device, its suitability for
my medical condition, or its maintenance, supplies or repairs. I understand that no warranty is being provided with the
CPAP/APAP/BiLevel Equipment Package.

___________________________________________  __________________________________________
Patient Signature                              Date