

# CPAP Assistance Program of the American Sleep Apnea Association

163 Third Street • Tracy, MN 56175 • 507/629-6065 • Fax 507/412-8249

## Physician Authorization Form for Donated CPAP/BiPAP Equipment

Dear Physician:

One of your patients is requesting donated materials from the American Sleep Apnea Association CPAP Assistance Program, or CAP. CAP is a nationwide donation program assisting individuals who find themselves in extreme financial hardship. Because of limited supply, it is imperative that these donated materials find their way to those most in need. We do not require financial statements, proof of disability, unemployment status, or the like. We do ask, however, that the physician, social worker, or clinician make a *good faith effort* to assist us in establishing patient need.

If you feel that your patient is a good candidate for donated CPAP/BiPAP equipment, please authorize the program administrator to dispense these items by providing a physician signature at the bottom of this page, and by completing the accompanying brief authorization form. The equipment will 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.

This cover letter or a copy of it must be signed by the physician, and returned with the completed application. A licensed respiratory therapist dispenses all donated equipment.

Respectfully,



Mark Seager, RRT  
Administrator of CAP  
Minnesota License No.2958  
Member, National Board of Respiratory Care

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

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## Application for donated materials – patient information

Patient name: \_\_\_\_\_

Patient date of birth: \_\_\_/\_\_\_/\_\_\_

Patient address: \_\_\_\_\_

Patient phone \_\_\_\_\_

### Equipment overview

*Please check the following that apply and specify pressure requirements:*

\_\_\_ CPAP machine and accessories

Pressure Setting in cwp: \_\_\_

\_\_\_ Automatic CPAP machine and accessories

Pressure range in cwp: max \_\_\_/min \_\_\_

\_\_\_ BiPAP machine and accessories

Insp. pressure in cwp \_\_\_ exhal. pressure in cwp \_\_\_

Mask size and style (i.e., medium nasal pillow, large nasal interface, etc.):

\_\_\_\_\_  
“Accessories” include heated humidifier if available, filters, and tubing. If a nasal interface (mask) is needed as part of this donation request, a size, and style must be specified here.

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## Application for donated materials – physician information

Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

Physician office/clinic phone \_\_\_\_\_

Date of application: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician license/NPID No.: \_\_\_\_\_

Clinician or agency to where the equipment is to be shipped: \_\_\_\_\_

Address: \_\_\_\_\_

Physician signature: \_\_\_\_\_