CPAP ASSISTANCE PROGRAM

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

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 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 mask is considered extra to the package and is not guaranteed. Please select a mask style and size on the form and we will include if we have your choice in our inventory. At this time, we have no BiLevels in our inventory and a limited supply of AutoCPAPs. 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.
$100 program fee per equipment package must be paid prior to shipping. This defrays program costs and allows us to help others.

First Name__________________________ Last Name___________________________________

Email___________________________________Phone_____________________________________

Mailing Address
Street Address____

City___________________________________State____________Zip________________________

Choose equipment package (BiLevel not available, limited supply of AutoCPAPs)
☐ CPAP

Mask Size
☐ Small ☐ Medium ☐ Large ☐ No Mask

Mask Style
☐ Full Face ☐ Nasal Mask ☐ Nasal Pillow

Send us a valid prescription:
Email to manager@sleepapnea.org or Fax to 888-293-3650

Please pay the $100 (per CPAP) program fee by:
Money Order or Certified Check: Mail to ASAA-CAP, 524 Craig Ave., Tracy, MN 56175

Additional Comments or Instructions

Patient Acknowledgement

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 (1) related in any way to the CAP Equipment Package or my use of the CAP Equipment Package provided; and (2) otherwise related to my participation in the CPAP Assistance Program. I understand and acknowledge that the ASAA is not responsible for the medical device, its suitability for my medical condition, or its maintenance, supplies or repairs. 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 acknowledge that the CAP Equipment Package does not include a humidifier and does not come with manufacturer warranty or support. I acknowledge that a mask is a bonus and not a guaranteed part of the CAP Package.

I agree to the patient acknowledgement above

Signature: ____