

Complete and Return All Pages via U.S. Mail -- this application cannot be accepted via fax

# Awake In America

A 501(c)(3) Pennsylvania corporation

P.O. Box 51601 • Philadelphia, PA 19115-6601 • 215-764-6568

<http://AwakeInAmerica.info/admin/contact-us/> • <http://www.AwakeInAmerica.org/disaster/>

## **OPERATION RESTORE CPAP**

*Awake In America Disaster ID:* \_\_\_\_\_ *Expires* \_\_\_ / \_\_\_ / \_\_\_

Awake In America originally launched **Operation Restore CPAP** on August 30, 2005, to aid victims of Hurricane Katrina who had been previously diagnosed with sleep apnea; who were being successfully treated with xPAP immediately prior to the hurricanes; and who lost their xPAP equipment in the hurricanes. Since then, **Operation Restore CPAP** has been authorized for use several times by Awake In America's Board, providing assistance to individuals in other disaster situations, including during California wild fires, tornadoes in the Midwest, and at other times.

**Operation Restore CPAP** is a streamlined version of Awake In America's **xPAP Donation and Relief Program** which was established in 2004 to help put xPAP equipment essential to treating sleep apnea in the hands of individuals who lack health insurance or the financial means to obtain it. Over the past year, the **xPAP Donation and Relief Program** has helped hundreds of individuals around the United States obtain the equipment they needed to treat their apnea.

Individuals applying for emergency replacement of their xPAP equipment, such as CPAP and bi-level ("BiPAP") machines; tubing; masks; humidifiers; and filters, will need to furnish specific information to verify they were victims of disasters approved for coverage by Awake In America's Board. Because most of the traditional documents, such as pay stubs, mortgage or rental agreements, and other paperwork was most likely destroyed, Awake In America relies largely on records being generated by other agencies operating in the federally-declared disaster area(s).

**At least two of the documents listed below must be submitted with this application:**

- Driver's license or other government-issued identification card
- **Copy** of FEMA paperwork
- Location, name, or site number of Red Cross shelter where you sought shelter, aid, assistance, or other services
- Copy of local/state disaster agency paperwork showing damage assessment
- Copy of insurance claim

## **Consent to Release of Information**

I, \_\_\_\_\_ (*print name clearly*), born \_\_\_\_\_ (*date of birth*), do hereby authorize the release of any records necessary by any agency, including the Federal Emergency Management Agency (FEMA), the American Red Cross or any of its local chapters or partners, any local, county/parish, or state-level agency that is involved with operations related to the disaster identified above, as well as any and all healthcare providers, including physicians, hospitals, treatment centers, military treatment facilities established for the disaster, or other health organization that rendered care or treatment to me in the disaster's aftermath.

The information being sought by Awake In America for its **Operation Restore CPAP** program will be used solely to verify eligibility for participation in this program. **Operation Restore CPAP** was created by Awake In America to replace life-sustaining equipment to individuals who had been diagnosed with sleep apnea prior to the disaster identified above, and who were being successfully treated with an xPAP device, such as a CPAP or bi-level (BiPAP) machine. Any information obtained will be used solely to determine the individuals eligibility for this program, and will not be shared with any other organization, agency, or entity for any purpose, nor will it be rented, leased, or sold.

I understand and agree that this Consent to Release of Information may also serve as a HIPAA release. In accordance with the standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following provides for the release of medical information to the appropriate listed personnel. There shall be no expressed limit on this HIPAA release, as certain information pertaining to my medical history may no longer exist or be readily available due to the disaster situation which currently exists.

\_\_\_\_\_  
(Applicant's legal name - *please print clearly*)

\_\_\_\_\_  
(Date of birth)

\_\_\_\_\_  
(Date signed)

\_\_\_\_\_  
(Applicant's legal signature)

\_\_\_\_\_  
(Applicant's social security number)

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## **OPERATION RESTORE CPAP**

### *Official Application*

Information about your current situation  
The fields below seek information on your current residence or shelter

Full legal name \_\_\_\_\_

Current street address (since identified disaster) \_\_\_\_\_

City \_\_\_\_\_ County / Parish \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Phone (home) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (cell) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone (Other) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (work) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Do you expect to be at this address for the next 30 days?  yes  no *If not, attach note with an address that will be valid for 30 days.*

Information about your permanent address  
The fields below seek information on your permanent address before the disaster

Permanent street address (prior to identified disaster) \_\_\_\_\_

City \_\_\_\_\_ County / Parish \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Phone (home) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (cell) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone (Other) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (work) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

How long did you reside there? \_\_\_\_ years \_\_\_\_ months Did you  own or  rent this home?

**Mortgage company or landlord's contact information:**

Company name \_\_\_\_\_

Contact person \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Office) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (fax / other) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Current condition of your home  
Describe the current situation involving your permanent home since identified disaster

Current condition of this residence:  Destroyed by fire  Flooded/underwater  major structural damage  Other (explain below)

Current condition of your xPAP equipment:  Left in house  lost/damaged during evacuation  Other (explain below)

Any additional comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## **OPERATION RESTORE CPAP**

### *Official Application*

All about your sleep apnea  
The fields below seek information on your apnea, treatment, and physician

Which do you use:  CPAP  BiPAP Current CPAP pressure: \_\_\_\_\_ cm/H2O Current BiPAP pressure: IPAP \_\_\_\_\_ / EPAP \_\_\_\_\_ cm/H2O

Type of mask:  nasal  full-face  nasal pillows Brand name (if known): \_\_\_\_\_

Do you use a humidifier?  yes  no Is it heated?  yes  no

Name of physician treating your sleep apnea: \_\_\_\_\_

Physician's Address (prior to identified disaster) \_\_\_\_\_

City \_\_\_\_\_ County / Parish \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Phone (Office) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (fax / other) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Information about your sleep lab  
The fields below seek information about your last sleep study

Sleep lab where your last sleep study was performed: \_\_\_\_\_

Sleep lab's Address (prior to identified disaster) \_\_\_\_\_

City \_\_\_\_\_ County / Parish \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Phone (Office) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone (fax / other) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Approximate date of last sleep study: (month) \_\_\_\_\_ (date) \_\_\_\_\_ (year) \_\_\_\_\_

Key Disaster Information  
The fields below seek information about the disaster and current claims

Have you filed an insurance claim on your xPAP equipment?  yes  no  not yet Are you going to?  yes  no

Have you filed a disaster claim with FEMA or other governmental agency?  yes  no  not yet Claim # \_\_\_\_\_

Do you currently have health insurance?  yes  no Carrier: \_\_\_\_\_

Health Insurance ID: \_\_\_\_\_ Group # / Name: \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Will your health insurance carrier replace your xPAP equipment?  yes  no  not sure/haven't checked yet

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## OPERATION RESTORE CPAP

### Official Application

#### xPAP Equipment Replacement

The fields below seek information about the donated equipment

If I receive new xPAP equipment from my health insurance carrier, I will return the equipment sent by Awake In America:  yes  no

If I receive new xPAP equipment from any governmental agency, I will return the equipment sent by Awake In America:  yes  no

If the need for my xPAP therapy ends within the next 18 months, I will return the equipment sent by Awake In America:  yes  no

If I do not use the xPAP equipment sent by Awake In America, I will return the equipment sent by Awake In America:  yes  no

#### Agreement and Sworn Statement

The section below is your agreement and testament to the accuracy of application

I, \_\_\_\_\_ (*print name clearly*), born on \_\_\_\_\_ (*date of birth*), do hereby affirm that all information contained in this application is true and correct to the best of my knowledge. I further affirm there are no misleading statements about my current condition. I understand Awake In America will verify the information prior to sending me equipment, to ensure I am eligible under its *Operation Restore CPAP* program, which is intended to aid apneic victims of the disaster identified above who lost their xPAP equipment. I understand Awake In America will ship the equipment to my current address, as listed on Page 2, in the "current information" section of this application, and will be sent via the U.S. Postal Service's Priority Mail program. I understand I am under no obligation to apply for Awake In America's *Operation Restore CPAP* program, that it is voluntary, and that I will not be charged any fees for services under this program. I understand that all equipment is donated, and may be either used or new, but in good, operable condition. I further understand that Awake In America has no agents or representatives who will ask that I pay for any costs associated with this program, now or in the future.

I further understand Awake In America is a non-profit organization, and as such, relies on donations from individuals, businesses, and corporations for financial support and equipment donations. I understand Awake In America may not be able to immediately supply me with equipment, as demand for equipment may be greater than what's in the organization's inventory at specific times. I further understand, based on donations received by Awake In America, the organization may not be able to exactly match the equipment I was using prior to the disaster identified in this application, but will ensure the equipment sent to me will satisfy my therapeutic needs. I further agree to waive and hold harmless Awake In America, its officers, as well as any donors, manufacturers, and medical and durable medical equipment providers involved in my donation from any and all claims. I further agree Awake In America is hereby authorized to investigate my request for equipment, and may confirm the information supplied in this application with any sources necessary to determine my eligibility. I understand eligibility is focused solely on apneic victims of the disaster identified in this application-who lost their homes and property, including xPAP equipment, and is not based on income, race, religion, or other qualification. Equipment replacement by homeowners, renters, flood, or health insurance is a disqualification for *Operation Restore CPAP*, I understand Awake In America does not discriminate on the basis of race, creed, sex, height, weight, color, national or ethnic origin, sexual preference, physical limitations, or disabilities.

\_\_\_\_\_  
(Applicant's legal name - *please print clearly*)

\_\_\_\_\_  
(Date signed)

\_\_\_\_\_  
(Applicant's legal signature)

\_\_\_\_\_  
(Applicant's social security number)

#### ~~ Awake In America Use Only ~~

Date Received: \_\_\_/\_\_\_/\_\_\_ ARC confirmation: Y / N \_\_\_/\_\_\_/\_\_\_ (office) \_\_\_\_\_ FEMA confirm: Y / N (date) \_\_\_\_\_  
 M.D. confirmation: Y / N \_\_\_/\_\_\_/\_\_\_ PSG/lab confirm: Y / N \_\_\_/\_\_\_/\_\_\_ Insurance confirm: Y / N \_\_\_/\_\_\_/\_\_\_  
 Approved: Y / N \_\_\_/\_\_\_/\_\_\_ Date Shipped via USPS Priority Mail: \_\_\_/\_\_\_/\_\_\_ Insured for: \$ \_\_\_\_\_ # \_\_\_\_\_