



Application for hair replacement

Wigs for Kids – Application Form
24231 Center Ridge Road
Westlake, Ohio 44145

Phone: 440-333-4433

Fax: 440-835-1084

E-mail: office@wigsforkids.org

Before sending this application, please ensure that all information is completed and that all of the following documents are enclosed. Otherwise, the application will not be approved.

Section 1: Patient Information

_____ Copy of ONE of the following: birth certificate, driver's license, state issued ID or document to show proof of recipient's age

Section 2: Medical Information

Section 3: Referral Information

_____ Official signature and office **stamp required**

_____ Prescription for a cranial prosthesis (if possible)

Section 4: Insurance Information

_____ Copy of insurance card

Section 5: Salon Information

Section 6: Supporting Wigs for Kids and Sponsor a Child agreement

How did you hear about Wigs for Kids?

SECTION ONE: Patient Information

Child's Name:

Gender: Male Female

Guardian(s) Name(s):

Age:

Date of birth:

Address:

City:

State/Province:

Zip or Postal Code:

Country:

Email:

Telephone:

School/Grade:

Are you a past recipient? Yes No

If yes:

When did you submit your last application? _____

When did you receive your last hairpiece? _____

Comments:

SECTION TWO: Medical Information

Reason for hair loss:

Please state illness/medical condition:

Are you undergoing medical treatment? Yes No

If yes, what type of treatment?

Have you already experienced hair loss? Yes No

Are you currently or will you soon be admitted to the hospital? Yes No

If so, for how long?

Name of Physician:

Hospital/Office address:

Do you have a prescription for a cranial prosthesis? Yes No

Please submit a copy with application.

SECTION THREE: Referral Information (ALL INFO MUST BE COMPLETE)

Name of Hospital /Organization:

Telephone:

E-mail:

Please circle one: Doctor Nurse Social Worker Other _____

Address:

City:

State/Province:

Zip:

Are you the primary contact for this recipient? Yes No

By signing this application, I, as a medical professional, hereby acknowledge and affirm that

- 1) There is a medical need of this patient for this prosthetic device and
- 2) This family would otherwise not be able to afford payment of this prosthetic device.

Name of Representative (Please print): _____

Signature of Representative: _____ Date: ____/____/____

An official stamp or documentation from a medical professional (i.e. prescription, doctor's note, etc.) is required. Please include below or attach a copy to application.

SECTION FOUR: Insurance Information

Do you have medical insurance? Yes No

If yes, name of insurance company:

Address:

Phone:

(COMPLETE ADDRESS AND PHONE - COPY FRONT AND BACK OF CARD)

Policy No.

Does your insurance cover prosthetic devices? Yes No

SECTION FIVE: Salon Information

Please include the contact name, salon name, address and telephone number of a local HAIR REPLACEMENT CENTER in your area. If you are unsure, search for Hair Replacement Centers in the Yellow Pages or yp.com. We ask that you assist us in contacting them to ask if they will work with you to provide measurements and final cutting and styling of the hair piece once it has been created. Wigs for Kids will send a detailed instruction form for measurements. If you need assistance with finding a hair replacement center please contact us at 440-333-4433. The accuracy of the measurements is CRITICAL, as well as the cutting and styling of the hairpiece.

Salon Name:

Address:

City, State, Zip:

Contact Person:

Phone:

Fax:

Email:

Website:

Email and website are essential for continued communication with the salon for WFK Updates and Information.

They are a Hair Replacement Center

Not a Hair Replacement Center

Salon License Number _____

SECTION 6: Supporting Wigs for Kids

Sponsor a Child Program

As you know, Wigs for Kids covers the costs of these customized hairpieces, products, and consultation fees, but as a non-profit organization, we are constantly seeking funds to offset these costs. One ongoing fundraiser is our Sponsor-a-Kid program, in which donors agree to cover the costs for one of our recipients. For each of our recipients, we create a story that focuses on his or her personality, interests, and personal story with hair loss and with Wigs for Kids. We value our recipients' privacy, and we do not disclose personal information such as last names, parents' names, addresses, or phone numbers. By signing below, you agree to help us to compile a story by sending us information about yourself, before and after photos, and a thank you letter after you receive your hairpiece.

I agree to participate in the Sponsor-a-Kid Program.

X _____
Applicant Signature

Date: _____

X _____
Parent/Guardian Signature

Date: _____

Please select any additional ways that you would be willing to support Wigs for Kids.

_____ I will put together a team in my local area to support the Wigs for Kids Annual Zoo Walk and 5K Run (held the last weekend in July).

_____ I will speak about my experience with Wigs for Kids at one or more fundraising events through Wigs for Kids.

_____ I will hold a cut-a-thon or third party fundraiser to raise funds and awareness about Wigs for Kids.

_____ I will make a financial donation to Wigs for Kids.