



Angel Hair Foundation
PO Box 2727
Eugene, OR 97402
debbie@angelhairfoundation.org
(541) 344-5135
www.angelhairfoundation.org

APPLICATION STEP ONE: BASIC INFORMATION

Last name

First name

Mailing address

City

State

Zip code

Phone number

Email address

Birth date (MM/DD/YEAR)

Age

Gender

Parent / Guardian name

Relation to applicant



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APPLICATION STEP TWO: MEDICAL INFORMATION

What is your medical diagnosis or condition?

What is your diagnostic code?

Are you currently undergoing medical treatment?

YES

NO

If yes, what type of treatment? (CHEMOTHERAPY, RADIATION THERAPY, ETC.)

Have you already experienced hair loss?

Name of your physician

Hospital or medical center of treatment



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APPLICATION STEP 3: INSURANCE INFORMATION

Insurance company name (IF NONE, JUST WRITE N/A)

Insurer's phone number

Address

City

State

Zip code

Group Number (#)

ID Number (#)

Name of insured

Date of birth of insured (MM/DD/YEAR)

Employer name

Address (IF DIFFERENT FROM CHILD'S ADDRESS ABOVE)



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APPLICATION STEP 4: FEEDBACK

How did you hear about Angel Hair Foundation's services?

I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to Angel Hair Foundation.

Signature

Date

PLEASE SUBMIT COMPLETED FORM TO:

Angel Hair Foundation

PO Box 2727

Eugene, OR 97402

OR BY EMAIL TO:

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