Angel Hair Foundation
PO Box 2727
Eugene, OR 97402
debbie@angelhairfoundation.org
541-915-8683
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:**
**debbie@angelhairfoundation.org**