Angel Hair Foundation
PO Box 2727, Eugene, OR 97402 | jeannine@angelhairfoundation.org
541-915-8683 | www.angelhairfoundation.org

APPLICATION STEP 1 BASIC INFORMATION

☐ I request that Angel Hair Foundation can communicate my protected health information via email and online application submission, that is not encrypted or otherwise secured. I am aware that my health information will be sent over an unsecured network and could be intercepted and used for identity theft purposes. I hereby accept those risks and absolve Angel Hair Foundation of any liability for these electronic transmissions.

Last Name

First Name

Mailing Address

City

State

Zip

Phone

Email

Birth Date (MM/DD/YEAR)

Gender

Parent/Guardian Name

Relationship To Applicant

APPLICATION STEP 2 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 kind of treatment? (Chemotherapy, radiation therapy, etc.)

Have you already experienced hair loss?

☐ Yes ☐ No

Name of your physician

Hospital or medical center of treatment

APPLICATION STEP 3 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