



A child's Voice[®]
FOUNDATION
"Where Kids Come First"

ANGEL HAIR FOR KIDS[®] INTAKE FORM





Dear Parent/Health Care Professional,

Enclosed is a copy of the intake form the Angel Hair for Kids® Program uses to process requests for wigs and hair prosthesis for children with special needs and medical conditions. We ask that you read and accurately complete the forms and attach any additional information that you feel will assist in processing the application, and fax it to 905-275-3139. Should a conversation be needed, please call 1-888-837-3354, 905-275-3434 or email admin@acvf.ca, and we will be happy to assist you.

To assess each individual case effectively, it is necessary to provide the information required to ensure that the child will receive the necessary support as soon as possible. We are required to have a current, clear and identifiable picture of your child for our records and to aid us in monitoring the quality of our service. Please provide this important and crucial part of the application. Failure to do so will result in the delay or disallowance of processing the application, once received.

I would like you to be aware that protecting the privacy and confidentiality of personal information is essential. This is the keystone of the services approach that A Child's Voice® Foundation takes to fulfilling its mission, the principle used by all involved with Angel Hair for Kids®.

On behalf of Angel Hair for Kids®, thank you for your cooperation in assisting us in serving children with special needs and medical conditions. Working together we can and will create an environment "Where Kids Come First".

Sincerely,

Dolores Esposito
Executive Director
A Child's Voice Foundation



IMAGE FORM

We are required to have a current, clear and identifiable picture of your child for our confidential records and to aid us in monitoring the quality of our service. Please provide this important and crucial component of the application.

Applications received without a picture may experience a delay in processing.

Date: _____

Child _____

I, (Parent/Guardian) of _____ (known as child) understand that A Child's Voice® Foundation and its program, Angel Hair for Kids®, require a photo to be taken of _____ (Child) to be attached to the child's file, as per the rules and guidelines of A Child's Voice® Foundation. The use will only be for the purposes of proving to Government bodies and the board of Directors that a wig was provided to this child. The photo will remain in the child's file at all times.

Signature of Parent/Guardian _____

Witness _____

Date: _____



ANGEL HAIR FOR KIDS®
Intake Form

To be filled out by the Health Care Professional and family requesting assistance.

Date of Request _____

CONTACT INFORMATION

Child's Name _____
Surname First Name Middle Initial

☐ Female ☐ Male Age _____ Date of Birth _____

Parent/Guardian Name _____
Surname First Name

Street Address _____

City _____ Prov _____ Postal Code _____

Telephone: Home _____ Cell _____ Work _____

E-mail Address _____

How did you find out about A Child's Voice® Angel Hair for Kids® Program?



REFERRAL INFORMATION

NAME OF HEALTH CARE PROFESSIONAL _____

AGENCY/ORGANIZATION _____

ADDRESS _____

CITY _____ PROV _____ POSTAL CODE _____

TELEPHONE _____ FAX _____

E-MAIL ADDRESS _____



MEDICAL INFORMATION

Reason for hair loss

Is the child undergoing medical treatment? If yes, please explain.

Name of Physician, Hospital/Office Location (If different from above)

Medical condition certified by: _____
Name of Medical Professional, Agency, Hospital

Address _____

Signature _____



FINANCIAL INFORMATION

Is there medical insurance? ☐ yes ☐ no

IF YES, please provide the complete name and address for the company and the amount allowed for **services or products**.

Does the family receive any other funding?

☐ yes (amount _____) ☐ no

Family Status/Guardian Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please **provide parent(s) or guardian's most recent Tax Return**. The total family income is required. Or Any documents or letters that verify extenuating financial circumstances.

OTHER INFORMATION

Please attach any other additional information about the applicant and or family so that we may offer them the best care.

BY SIGNING THIS INTAKE FORM YOU ARE STATING THAT THERE IS A FINANCIAL NEED ON BEHALF OF THE RECIPIENT.

Signature of Health Care Professional _____



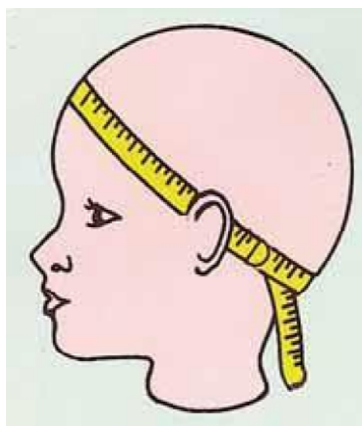
ORDER A WIG FOR AN ANGEL HAIR FOR KIDS[®] RECIPIENT

RECIPIENT'S NAME _____

Angel Hair for Kids[®] Wigs are made with the human hair that was graciously donated by other children and with money raised, a wig for a child is made. The AHFK wigs comes in 3 sizes, designed with 12" hair length and with a light density to give the most natural look.

SIZE

Please measure your child's head as shown in the diagram and record it in the space provided.



The Recipient's circumference is:

_____ inches

Angel Hair for Kids wigs comes in the following circumferences:

- XS: 19" - 20"
- S: 20 ½"
- M: 21"

HAIR COLOUR

As for the colour of the hair, our AHFK wigs come in 5 colours. We will match your child's hair as close as possible to the available colours.

Please provide a colour photo of your child showing their hair so that we can match the colour. Please send this form along with the application to dee@acvf.ca



CHECK LIST FOR ANGEL HAIR FOR KIDS® INTAKE FORM

☐ Contact Information

☐ Medical Information

☐ Financial Information (medical insurance, marital status, tax returns, documents or letters)

☐ Signature of Health Care Professional

☐ Photo

☐ Head Measurement Form

FOR OFFICE USE

Date Received: _____

Date approved or declined: _____

Approved by: _____

Date letter/email sent out: _____