

Hair for You — Wig Request Application

Free custom wigs for minority women and children experiencing medical hair loss

Complete all sections in full. Submit by email to info@alternativesbeauty.org or mail to:
4737 Concord Pike, Suite 279 – 3rd Floor, Wilmington, DE 19803

SECTION 1 — Applicant Information

Full Legal Name

Date of Application

Preferred Name (if different)

Date of Birth

Gender Identity (optional)

Street Address

City

State

ZIP Code

County

Phone Number

Email Address

Best Way to Reach You

Is this request for yourself or someone in your care?

Myself

A child or dependent in my care

Both

If requesting for a child or dependent, please provide their name and age:

Name of Recipient (if different from applicant)

Recipient Age

How did you hear about Hair for You?

Social media

Friend or family

Doctor or nurse

Social worker or caseworker

Community organization

Internet search

Alternatives Beauty School

Other: _____

SECTION 2 — Medical Background & Hair Loss Cause

This information helps us understand your situation and create the most appropriate wig for you. Medical documentation is not required but may be requested in some cases. All information is kept strictly confidential.

Primary cause of hair loss: (check all that apply)

Cancer / chemotherapy

Cancer / radiation therapy

Alopecia areata

Alopecia totalis

Alopecia universalis

Traction alopecia

Trichotillomania

Autoimmune condition (e.g., lupus)

Burn injury

Surgical procedure

Postpartum hair loss

Other medical condition

Prefer not to say

Other: _____

Diagnosis or condition (if comfortable sharing)

Approximate date hair loss began

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Current stage of hair loss:

<input type="checkbox"/> Just beginning — partial hair loss	<input type="checkbox"/> Significant thinning
<input type="checkbox"/> Mostly or completely bald	<input type="checkbox"/> Hair loss is temporary (expected regrowth)
<input type="checkbox"/> Hair loss is permanent	<input type="checkbox"/> Unsure

Are you currently undergoing treatment?

<input type="checkbox"/> Yes — ongoing treatment	<input type="checkbox"/> Yes — recently completed treatment	<input type="checkbox"/> No treatment	<input type="checkbox"/> Not sure
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Please share any additional medical context you feel is relevant to your request (optional):

SECTION 3 — Hair Profile & Wig Preferences

This section helps our students craft a wig that fits well and feels like you. Answer as best you can — we will follow up if we need more details.

Your natural hair texture (before hair loss):

<input type="checkbox"/> Straight (Type 1)	<input type="checkbox"/> Wavy (Type 2a–2c)	<input type="checkbox"/> Curly (Type 3a–3c)
<input type="checkbox"/> Coily / kinky (Type 4a–4c)	<input type="checkbox"/> Not sure / varied	

Head circumference (if known, in inches)

Natural hair color

Preferred wig color

Preferred wig length:

<input type="checkbox"/> Short (above chin)	<input type="checkbox"/> Medium (chin to shoulder)	<input type="checkbox"/> Long (below shoulder)	<input type="checkbox"/> No preference
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Preferred wig style: (check all that apply)

<input type="checkbox"/> Natural / afro	<input type="checkbox"/> Loose curls	<input type="checkbox"/> Defined coils	<input type="checkbox"/> Straight
<input type="checkbox"/> Braided / protective style	<input type="checkbox"/> Locs	<input type="checkbox"/> Waves	<input type="checkbox"/> No preference

Do you have any sensitivities or physical considerations we should know about?

<input type="checkbox"/> Sensitive scalp	<input type="checkbox"/> Open wounds or sores on scalp
<input type="checkbox"/> Active treatment (port/lines near head)	<input type="checkbox"/> Latex allergy
<input type="checkbox"/> Adhesive sensitivity	<input type="checkbox"/> None

Any additional preferences, style notes, or special requests for your wig (optional):

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SECTION 4 — Personal Statement & Hardship Need

Hair for You is provided free of charge regardless of financial situation. This section helps us understand the personal impact of your hair loss and prioritize requests during high-demand periods.

Which of the following describe your current situation? (Check all that apply)

<input type="checkbox"/> Undergoing active cancer treatment	<input type="checkbox"/> Recently completed treatment
<input type="checkbox"/> Experiencing hair loss with no current treatment option	<input type="checkbox"/> Limited or no health insurance
<input type="checkbox"/> Cannot afford wig services elsewhere	<input type="checkbox"/> Survivor of domestic violence
<input type="checkbox"/> Single parent or primary caregiver	<input type="checkbox"/> Experiencing financial hardship
<input type="checkbox"/> Child or minor in need	<input type="checkbox"/> Other

Personal Statement — In your own words, tell us what receiving a wig would mean to you or your loved one. How has hair loss affected your daily life, confidence, or wellbeing? Share as much or as little as you are comfortable with. (100–300 words)

SECTION 5 — Supporting Contact

Please provide one person we may contact to support your request — this may be a doctor, nurse, social worker, caseworker, shelter advocate, or trusted community member. This is not required but helps us process requests more quickly.

Full Name

Relationship to Applicant

Organization / Practice (if applicable)

Phone Number

Email Address

Any additional notes from supporting contact (optional):

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SECTION 6 — Certification & Signature

I certify that all information provided in this application is true and accurate to the best of my knowledge. I understand that Hair for You services are provided free of charge and that submitting this application does not guarantee a wig will be provided. I authorize Alternatives Beauty to contact my supporting contact if listed. I understand that all personal and medical information shared will be kept strictly confidential and used solely to process this request.

Applicant Signature

Date

Printed Name

Submission Checklist — please confirm before sending:

<input type="checkbox"/> All sections completed in full	<input type="checkbox"/> Hair profile and preferences filled out (Section 3)
<input type="checkbox"/> Personal statement written (Section 4)	<input type="checkbox"/> Application signed and dated

Submit to: info@alternativesbeauty.org | or mail to: 4737 Concord Pike, Suite 279 – 3rd Floor, Wilmington, DE 19803
Questions? Call (302) 468-6609 or visit alternativesbeauty.org/programs/hair-for-you/

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