ALTERNATIVES BEAUTY • alternativesbeauty.org • (302) 468-6609 • info@alternativesbeauty.org

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:
4723 Concord Pike, 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:

■ Just beginning — partial hair loss	■ Significant thinning
■ Mostly or completely bald	■ Hair loss is temporary (expected regrowth)
■ Hair loss is permanent	■ Unsure

Are you currently undergoing treatment?

■ Yes — ongoing treatment	■ Yes — recently completed treatment	■ No treatment	■ Not sure

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):

■ Straight (Type 1)	■ Wavy (Type 2a–2c)	■ Curly (Type 3a–3c)
■ Coily / kinky (Type 4a–4c)	■ Not sure / varied	

Head circumference (if known, in inches) **Natural hair color** **Preferred wig color**

Preferred wig length:

■ Short (above chin)	■ Medium (chin to shoulder)	■ Long (below shoulder)	■ No preference

Preferred wig style: (check all that apply)

■ Natural / afro	■ Loose curls	■ Defined coils	■ Straight
■ Braided / protective style	■ Locs	■ Waves	■ No preference

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

■ Sensitive scalp	■ Open wounds or sores on scalp
■ Active treatment (port/lines near head)	■ Latex allergy
■ Adhesive sensitivity	■ 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)

■ Undergoing active cancer treatment	■ Recently completed treatment
■ Experiencing hair loss with no current treatment option	■ Limited or no health insurance
■ Cannot afford wig services elsewhere	■ Survivor of domestic violence
■ Single parent or primary caregiver	■ Experiencing financial hardship
■ Child or minor in need	■ 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:

■ All sections completed in full	■ Hair profile and preferences filled out (Section 3)
■ Personal statement written (Section 4)	■ Application signed and dated

Submit to: info@alternativesbeauty.org | or mail to: 4723 Concord Pike, , Wilmington, DE 19803
Questions? Call (302) 468-6609 or visit alternativesbeauty.org/programs/hair-for-you/