60 West Church Street, Bergenfield, NJ 07621 ✦ 201-837-6770
www.DoWondersCharity.org ✦ DoWondersCharity@gmail.com

Do Wonders Potential Recipient Application

APPLICANT INFORMATION		
Name:		
Current Address:		
City, State Zip:	E-mail:	
Date of Birth:	Home Ph.:	Cell Ph.:
Who is filling out this application? ❑ Self ❑ Other: Name_____ Relationship: _____		

MEDICAL INFORMATION	
1. Have chemotherapy or radiation been prescribed for you? ❑ Yes ❑ No	1a. If yes, please list date range of treatment: (MM,DD,YYYY)
2. Has your doctor written you a prescription for a wig? ❑ Yes ❑ No	2a. If yes, please attach prescription to this application.

FINANCIAL INFORMATION		
3. Please check (✓) if you or anyone in your household currently receives any of the following benefits: ❑ Medicaid ❑ SNAP (food stamps) ❑ Free/ reduced school meals ❑ WIC If none of these were checked, please proceed to question #4.		
4. Household gross income: (Only choose one)	❑ Annual:	❑ Monthly
	❑ Twice Monthly:	❑ Weekly:
4a. Number of people in your household:		
4b. ❑ Please check here if you wish to provide additional hardship information which would be useful in determining your eligibility. (Please use second page.)		

INSURANCE INFORMATION	
5. Do you have medical insurance? ❑ No ❑ Yes (Please attach a copy of your insurance card.)	
6. If you have insurance, do they cover the cost of a cranial prosthesis?	
❑ I don't know	Please take a moment to call them before continuing.
❑ Yes	As we are here to serve those who are otherwise not being served, we cannot give you a free wig through Do Wonders. We'd be happy to work with you through our business, Wigs by Lillian Lee. Upon purchase we will provide you with the paperwork your insurance company will request in order for you to be reimbursed.
❑ No	You might be a candidate for a Do Wonders. You must attach written confirmation from your insurance company that you do not have wig coverage, or have one of our agents speak with them.

REFERRAL INFORMATION	
7. How did you hear about us?	
8. Referring agency:	8a. Agency phone number:
9. Contact name:	

ADDITIONAL INFORMATION

If there is any additional information you think would be helpful for us to make our determination (extenuating circumstances, etc.) please let us know here.

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SIGNATURE

I understand that Do Wonders is a non-profit with limited resources, designed to assist people in financial need to obtain a cranial prosthesis (wig). By signing this form, I certify the following:

- I have financial need and request consideration for this service.
- The information provided on this form is factual, and has not been falsified or misrepresented in any way.

Signature:	Date:
Name printed:	Relationship to applicant:

PHOTO RELEASE

I grant Do Wonders the right to take photographs of me in relation to receiving a cranial prosthesis from the charity. I authorize Do Wonders, its assignees and transferees to copyright, use, and publish the same in print or electronically. I agree that Do Wonders may use such photographs of me for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and web content. I have read and understand the above.

Do Wonders ❑ may ❑ may not use my first name only alongside my photo. I understand that last names will never be used.

Applicant signature:	Date:

FOR FOUNDATION USE ONLY. PLEASE DO NOT WRITE BELOW THIS LINE.

❑ Verification process complete:	Authorized signature:
	Date:
❑ Approved ❑ Denied	Authorized signature:
	Date: