AAAF
Australia Alopecia Areata Foundation
Alopecia Areata .....it's life changing

Wigs for Kids Program

The AAAF believes that whether to wear a wig or not is a personal choice. As government assistance and Medicare / Private Health Care rebates are limited and vary across states, the AAAF established the Wig for Kids program to ensure that children wanting to wear a wig get the information, service and support needed.

Application Criteria:

- The amount awarded is a total of $400.00 inclusive of GST.
- A child for the purpose of this program is a person of 17 years or under.
- To help care for the wig the amount granted can include the purchase of a wig stand, hair brush, speciality shampoos and conditioners, as well as the cost of the wig or part thereof with the cost of the wig
- AAAF can provide a list of Wig Providers in your state. A Wig Provider needs to be selected as part of this application. AAAF has the right to refuse the Wig Provider if we do not believe the Wig Provider will provide an overall positive experience and quality product for the child.
- The successful applicant will receive a voucher to present to the Wig Provider on collection of the wig. The Wig Provider will invoice AAAF directly quoting the voucher reference number.
- Before deciding on a wig, find out as much information as you can from various Wig Providers. There are some useful guidelines and tips available on purchasing a wig on our website - www.aaaf.org.au

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Wigs for Kids Application

Applicants Details:			
Last Name:		First Name:	
Male ☐	Female ☐	**Date of Birth:**	
Residential Address		**Suburb/Town:**	
		Postcode	**State:**
Postal Address:		**Home Telephone:**	
		Work/Mobile:	
Email address:			
Guardian/Next of Kin/Contact Person (18+):			
Last Name:		First Name:	
Relationship to Applicant:			
Residential Address		**Suburb/Town:**	
		Postcode	**State:**
Telephone:		**Mobile/Work:**	
Email address:			

Please answer all questions:		
1	What form of Alopecia do you currently have? Alopecia Areata; (AA) Alopecia Totalis; (AT) Alopecia Universalis. (AU)	**AA** ☐ **AT** ☐ **AU** ☐
2	What year were you first diagnosed?	
3	Is this your first wig?	
4	Reason for wig purchase? i.e. new wig, replacement wig	
	Details of wig:	
5	*Please provide name and contact details of Wig Provider:*	
	Wig Provider Name:	Email:
	Address:	Phone number:

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6	Amount requested:	$
7	Are you in receipt of a Pension / Allowance / Health Care card?	Yes ☐ No ☐
8	We would appreciate a testimonial that can be used to report back the success of this program?	
	a. Will you provide a photo wearing the new wig?	Yes ☐ No ☐
	b. Will you provide a 50 word statement that can be posted onto our web site?	Yes ☐ No ☐
	c. Would you like your name used in the testimonial?	Yes ☐ No ☐
	d. Did the Wig Provider provide a list of things NOT to do with your wig?	Yes ☐ No ☐
	e. Did the Wig Provider offer follow up appointments to cut /style or wash your wig?	Yes ☐ No ☐
	f. Please rate your overall experience?	Poor ☐ Good ☐ Excellent ☐
9	Please provide any further information that you think is relevant to assist us in providing assistance to you or to support this application.	

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APPLICANT DECLARATION

I confirm that my signature below represents:
• My agreement to enquiries being made by the Australia Alopecia Areata Foundation to other individuals and organisations, for the purpose of obtaining information about eligibility and assessment for the requested funding.
• My understanding that all the information I have supplied on this application is true and correct to the best of my knowledge.
• My understanding that this application is not a formal approval or guarantee of acceptance into this program.
• My understanding that the decision of the Australia Alopecia Areata Foundation committee is final and not subject to any appeal.
• My understanding that I can claim only once.
• By signing this declaration my details will be registered on the AAAF register and will not be provided to external parties.

Parent/Guardian Signature		**Date**	
Client Signature		**Date**	

PRIVACY STATEMENT

Information that you have provided will only be used to provide services that you request and will not be used for any other purposes without your express consent. You have the right to request access to your information and to have it corrected where it is inaccurate, out of date, incomplete or misleading.

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Confirmation of Alopecia Areata

Please attach a confirmation letter from your GP or have the following form completed.

Please note Doctor's contact details must be completed (or Stamped)

I _____ confirm that _____

(Name of Signatory) (Name of applicant)

has a diagnosis of _____which is permanent in nature.

(diagnosis)

NAME and SIGNATURE (Complete ONE only)	
1.	**INITIAL confirmation of any form of Alopecia Areata**
	Signature of Doctor:
	Date:
	Business Name & Address: (please ensure this is completed)

2.	**ONGOING confirmation of any form of Alopecia Areata**
	Signature of Assessor:
	Date:
	Address:

Please return the completed form to:

AAAF
PO Box 5029
Frankston South Vic 3199

Or via Email: info@aaaf.org.au

FOR OFFICE USE ONLY

DATE RECEIVED: ……/……../…… **DATE APPROVED:** ……../……../……

VOUCHER NO: …… **AMOUNT PAID:** $ ……

SIGNED:…… **PRINT NAME:** ……