CANCER WIG FOUNDATION, INC.
WIG REIMBURSEMENT FOR CANCER PATIENTS

REIMBURSEMENT POLICY

Funds raised for the Cancer Wig Foundation, Inc. will be used to reimburse Minnesota resident cancer patients for a wig or prosthetic needed for medical hair loss caused by cancer treatment. The Cancer Wig Foundation, Inc. is not part of the Look Good Feel Better program nor is it associated with the American Cancer Society. The Cancer Wig Foundation, Inc. is funded strictly by donations from individuals, civic groups, corporations and fund raisers. This foundation is a 501(c)3 organization and all donations are tax deductible.

1. Referrals must come from a cosmetologist, esthetician or nail technician who is a member of the Salon & Spa Professional Association (SSPA). The cosmetologist portion of the request form must be completed by the SSPA member with an original signature. Copies, facsimile, or signatures other than that of an SSPA member will not be accepted. A SSPA membership number must be included.

2. Reimbursement up to $50.00 will be allowed for only one wig purchased by any one cancer patient per life time. Reimbursements will be made in order received as funds are available.

3. A receipt and a doctor's prescription must be presented with the appropriate form completed by the cancer patient and SSPA member. The cancer patient, not the SSPA members, must sign the form.

4. Wig may be purchased from any source.

5. The cancer patient must currently be receiving radiation or chemotherapy treatment.

6. The cancer patient must be a resident of the State of Minnesota.

7. Requests must be submitted within 60 (sixty) days of the wig purchase date to receive reimbursement.

8. Reimbursement requests MUST meet the criteria in order to be eligible for reimbursement. Forms that are not filled out completely will be returned to the member cosmetologist and/or cancer patient.

9. Reimbursements will be paid to the cancer patient only. Requests for payment to the cosmetologist will not be honored.

10. Requests must be from a cancer patient who has suffered hair loss. Requests from individuals who have suffered hair loss due to a medical condition other than cancer will not be honored.

11. Requests for reimbursements must be sent to:

Cancer Wig Foundation, Inc.
C/O SSPA
2626 E. 82nd Street, Suite 340
Bloomington, MN 55425
Telephone: 952/925-9731

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Cancer Patient Reimbursement Request Form

Date_____

Patient's Name_____

Street Address_____

City, State & Zip_____
(Patient must be a resident of Minnesota)

Telephone (_____)_____Email_____

Cancer Diagnosis (required)_____

Patient's Signature_____

Cost of wig purchased $_____

Where purchased: Store/Salon_____

Address_____

Attending Physician_____Telephone_____

Optional information: Was this wig for a _____man _____woman _____child

Approximate age_____

Referred by Salon & Spa Professional Association Member ONLY:

SSPA/NCA Member # _____exp date_____

Name_____

Street Address_____

City, State & Zip_____Telephone (_____)_____

SSPA Member Signature_____

This form must be completed and submitted by a member of SSPA and must include sales receipt and a doctor's prescription for reimbursement.

Mail to: Cancer Wig Foundation Inc.
C/O SSPA
2626 E. 82nd Street, Suite 340
Bloomington, MN 55425