



Wishcaps Cares

Patient Financial Assistance Application

Helping make cold cap therapy more accessible

At Wishcaps, we understand that cancer treatment can create unexpected financial challenges. Our Patient Financial Assistance Program is designed to help qualifying patients who may have difficulty affording cold cap therapy due to limited income, fixed income, or financial hardship.

Assistance is based on individual circumstances and available program funding. Completing this application does not guarantee approval.

Section 1 — Patient Information

Full Name: _____

Email Address: _____

Phone Number: _____

City / State: _____

Section 2 — Treatment Information

Expected chemotherapy start date: _____

Estimated number of treatments: _____

Have you already started chemotherapy?

☐ Yes

☐ No

Section 3 — Financial Information

Current employment or income status (select all that apply):

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Retired / Fixed income
- ☐ Receiving disability benefits
- ☐ Unemployed
- ☐ Unable to work due to medical treatment
- ☐ Other

Total annual household income (before taxes):

- ☐ Under \$25,000
- ☐ \$25,000–\$39,999
- ☐ \$40,000–\$59,999
- ☐ \$60,000–\$79,999
- ☐ \$80,000 or more
- ☐ Prefer not to disclose

Number of people in household: _____

Are you experiencing financial hardship related to your medical treatment?

- ☐ Yes
- ☐ No
- ☐ Prefer not to disclose

Section 4 — Assistance Requested

What level of financial assistance would help you participate in cold cap therapy?

- ☐ Partial assistance with monthly lease payments
- ☐ Significant assistance with monthly lease payments
- ☐ Maximum assistance available
- ☐ Unsure — please help determine eligibility

Optional: Please briefly describe any circumstances you would like us to consider.

Section 5 — Patient Acknowledgment

By submitting this application, I confirm that the information provided is accurate to the best of my knowledge.

I understand that:

- Financial assistance is subject to approval and available program funding.
- Assistance applies only to the charges specifically identified in my approval.
- Approved assistance does not guarantee hair preservation or treatment results.
- Standard lease terms and equipment return requirements remain in effect unless otherwise agreed in writing.
- Wishcaps may request reasonable additional information to verify eligibility.
- My application information will be handled confidentially and used to evaluate my request.

☐ I acknowledge and agree to the above statements.

Patient Signature: _____

Date: _____

Wishcaps Patient Assistance Team

1-844-WISHCAP

www.wishcaps.com

Applications are generally reviewed within 1–2 business days. Additional information may be requested when necessary.