



Beauty Bus Foundation
11301 Olympic Blvd. # 303
Los Angeles, CA 90064
phone 310.287.1272 | fax 310.287.1271

BEAUTY BUS FOUNDATION
CLIENT AND CAREGIVER APPLICATION

Please return completed application form (5 PAGES) to Beauty Bus Foundation

via one of the following:

Mail: 11301 Olympic Blvd. #303, Los Angeles, CA 90064

Fax: 310-287-1271

Email: beauty@beautybus.org

The Beauty Bus Foundation is a non-profit organization dedicated to enhancing the quality of life for homebound, chronically and terminally ill people and their primary caregivers by bringing beauty into their lives. We provide at-home beauty and grooming treatments, free of charge, to empower our clients, help them maintain dignity and give them a small departure during a difficult time.

Services are performed by trained beauty professionals who are accompanied on each home visit by another Beauty Bus volunteer, the Beauty Buddy. Each service lasts approximately one-hour. If there is a caregiver, he or she must be at home and available during the client's Beauty Bus visit.

Beauty Bus services clients with: ALS (Lou Gehrig's Disease), Cancer, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Spinal Cord Injuries, and Stroke. Clients and caregivers are seen at the same visit and can determine when to use their four beauty treatments throughout each year, subject to volunteer availability.

Today's Date: _____

CLIENT INFORMATION

First Name Middle Last Name

Mailing Address

City State Zip Code

() _____ () _____
Home Number Work Number

() _____ () _____
Cell Phone/Pager FAX

Email Address: _____

Date of Birth: _____ **Sex:** ___ Male ___ Female

Client is primarily homebound and has one of the following diseases or conditions that Beauty Bus services: (please check)

- | | | |
|----------------------------------|---------------------------|--------------------------|
| _____ ALS (Lou Gehrig's Disease) | _____ Cancer | _____ Multiple Sclerosis |
| _____ Muscular Dystrophy | _____ Parkinson's Disease | |
| _____ Spinal Cord Injuries | _____ Stroke | |

Does client have any communicable diseases or other conditions that could affect his/her ability to receive Beauty Bus beauty services? ___ Yes ___ No

If Yes, please explain: _____

Does client have any allergies to products or any allergies that would affect Beauty Bus services? ___ Yes ___ No

If Yes, please explain: _____

Is there anything else that will affect Beauty Bus services of which Beauty Bus should be aware? _____

Do you have any pets in your home? ___ Yes ___ No

If Yes, please list: _____

SERVICES REQUESTED

Client and Caregiver Request the Following Service(s).

Please rank in order of preference (1 being first choice; 5 being last choice). Do not rank services you cannot have or do not want. Note that we can only send one Beauty Professional, so client and caregiver must receive same service at each visit. Clients can determine when to use their four beauty treatments throughout the year and which treatments to receive at each visit, subject to volunteer availability.

- _____ Hair Cut, Styling and/or Blow Dry (no hair washing)
- _____ Makeup Application
- _____ Manicure/Men’s Manicure
- _____ Mini Facial
- _____ Pedicure/Men’s Pedicure

APPOINTMENT TIME PREFERENCE

Please list your preferences for times and days of service - 1 being your first choice and proceeding numerically. If there are any times that will not work, please mark them with an X. Please be as specific as possible.

Beauty Bus will do our best to match volunteers with your requests. Please note that our volunteers do not have to travel more than 5 miles from their home or place of business, and our ability to provide services is subject to volunteer availability. Our current service area is available on our website – www.beautybus.org.

Mondays	_____	Morning	_____	Afternoon	_____	Evening
Tuesdays	_____	Morning	_____	Afternoon	_____	Evening
Wednesdays	_____	Morning	_____	Afternoon	_____	Evening
Thursdays	_____	Morning	_____	Afternoon	_____	Evening
Fridays	_____	Morning	_____	Afternoon	_____	Evening
Saturdays	_____	Morning	_____	Afternoon	_____	Evening
Sundays	_____	Morning	_____	Afternoon	_____	Evening

CAREGIVER INFORMATION (IF APPLICABLE)

First Name Middle Last Name

Mailing Address

City State Zip Code

() _____ () _____
Home Number Work Number

() _____ () _____
Cell Phone/Pager FAX

Email Address: _____

Date of Birth: _____

Sex: ___ Male ___ Female

Relationship to Client: _____

Does the caregiver have any communicable diseases or other conditions that could affect his/her ability to receive Beauty Bus beauty services? ___ Yes ___ No
If Yes, please explain: _____

Does the caregiver have any allergies to products or any allergies that would affect Beauty Bus services? ___ Yes ___ No
If Yes, please explain: _____

Is there anything else that will affect Beauty Bus services of which Beauty Bus should be aware? _____

CONFIRMATION

I/we confirm that I/we understand the requirements for Beauty Bus services, including that the client is primarily homebound and suffers from a disease or condition serviced by Beauty Bus, and represent that I/we qualify for these services.

CLIENT CONFIRMATION

Print Client Name: _____

Client Signature: _____

Date: _____

CAREGIVER CONFIRMATION (IF APPLICABLE)

Print Caregiver Name: _____

Caregiver Signature: _____

Date: _____