Assistance League® of Salt Lake City ● P.O. Box 9353, Salt Lake City, UT 84109 ● Fax 801-484-0987

REQUEST for DONATION for DENTALTREATMENT

Assistance League of Salt Lake City is a 501 (c)(3) nonprofit, philanthropic organization contributing to children's dental health through its Operation Healthy Teeth Program. Qualified schools, agencies, or authorized dental professionals may make a request for donation. Acceptance is limited. **Eligibility Requirements: Children pre-K through 12th grade. Child's dental needs must be urgent and he/she must not be enrolled in a private or public dental plan or other charitable dental program. The child's Parent or Guardian must select two dentists from the list provided.**

TO BE COMPLETED BY SCHOOL COUNSELOR

Name: ____Title: __________________________Date_________________

Phone: ___________________________ Fax: ___________________________ Email: _______________________________________

School: ____

CHILD: Name ____ Age: _______ Boy/Girl: __________________

PARENT/GUARDIAN: Name: ____

Relationship to child: ____Child's Home Address and zip code: ______________

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Was the child seen by Sealants for Smiles? ____________
Is the child covered by private dental insurance? ___________
Is the child enrolled in the Children's Health Insurance Program (CHIP)? ___________
Is the child enrolled in another charitable program for dental care (i.e., Regence Caring Foundation, Head Start) _______________
Is the child enrolled in Medicaid? ___________

Briefly describe the child's condition:
____

Has the child missed school due to this condition? _____________ Will child or parent/guardian require an interpreter? ___________

Language: ______________________ **I have given the child's parent/guardian a copy of this completed request**. ___________

TO BE COMPLETED and SIGNED BY CHILD'S PARENT or GUARDIAN

I hereby request a financial donation from Assistance League of Salt Lake City to be paid to the selected dentist for urgent dental treatment for my child. I understand that the dentist is also making a donation on behalf of my child. If accepted:

- I understand that acceptance in this program is limited and expenditure is subject to available funding.
- I understand that this request is for the above named child only.
- I understand that I must select two dentists from the list provided.
- I understand a financial donation on behalf of my child is provided by Assistance League and paid directly to the dentist.
- I understand that the dentist who treats my child will also make a donation on behalf of my child.
- I understand that that acceptance of a new patient is at the dentist's discretion.

I, the Parent/Guardian, select (**please print**) **1.** Dr.__________________ and **2.** Dr.______________________ from the list provided.

Parent/Guardian Signature: ____ Date: __________________

FAX COMPLETED FORM TO ASSISTANCE LEAGUE – 801-484-0987