



REQUEST for CONTRIBUTION for DENTAL TREATMENT

TO BE COMPLETED BY DENTIST

Assistance League Authorization Number (if previously assigned) _____ Date _____

DENTIST: _____ Contact Person: _____

Phone: _____ Fax: _____

CHILD: Name _____ Age: _____ Boy/Girl: _____

PARENT/GUARDIAN: Name: _____

Relationship to child: _____

Child's Home Address and Zip Code: _____

Please describe or attach the treatment plan with estimated charges and the amount or percentage of your contribution. In the event you are requesting a contribution in excess of \$1,000 your request must be approved by Assistance League and will be subject to available funds.

Was child seen at the Give Kids A Smile clinic? _____

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 covered by Medicaid? _____

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

I request a financial contribution from Assistance League® of Salt Lake City to be paid to the above dentist for dental treatment for my child. If accepted:

- I understand that acceptance in this program is limited and expenditure subject to available funding.
- I understand that this request is for the above named child only.
- I understand a financial contribution on behalf of my child is provided by Assistance League.
- I understand a contribution on behalf of my child is provided by the dentist in participation with the Assistance League.

Parent/Guardian Signature: _____ Date: _____

Fax Completed Form to Assistance League (801) 484-0987