



**REQUEST for CONTRIBUTION for DENTAL TREATMENT**

**TO BE COMPLETED BY SCHOOL COUNSELOR**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

School: \_\_\_\_\_

**CHILD:** Name \_\_\_\_\_ Age: \_\_\_\_\_ Boy/Girl: \_\_\_\_\_

**PARENT/GUARDIAN:** Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Child's Home Address and zip code: \_\_\_\_\_

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? \_\_\_\_\_

Please briefly describe the child's condition.  
\_\_\_\_\_  
\_\_\_\_\_

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

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

I hereby request a financial contribution from Assistance League® of Salt Lake City to be paid to the selected dentist for dental treatment for 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 it is my responsibility to select a dentist from the list provided by Assistance League and to make an appointment for my child.
- 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 participating with Assistance League.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX COMPLETED FORM TO ASSISTANCE LEAGUE (801) 484-0987**