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

REQUEST for CONTRIBUTION of ONE TIME URGENT DENTAL TREATMENT

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.**

Please CIRCLE agency type making this request: **School** **Medical Clinic** **Dentist Office**

School and Medical Clinic request require parent dentist selection at the bottom of this form.

Requestor Name: _____ Title: _____ Date _____

Phone: _____ Fax: _____ Email: _____

If School list School's Name and District _____

If Medical Clinic list Clinic Name _____

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

PARENT/GUARDIAN: Name: _____

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

_____

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? _____

Has the child missed school due to this condition? _____
Briefly describe the child's condition

_____

_____

Will child or parent/guardian require an interpreter? _____ Language: _____

I have given the child's parent/guardian a copy of this completed request. _____

CHILD'S PARENT or GUARDIAN DENTIST SELECTION

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, the Parent /Guardian, select or authorize the sender of this form to select the following Dentists (**please print**)

1. Dr. _____ TN _____

2. Dr. _____ TN _____

Parent/Guardian signature is required

Parent/ Guardian Signature: _____ **Date** _____

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