

CHILDREN'S DENTAL ANGEL FUND

Program Information

The Humboldt Health Foundation (HHF), a supporting organization of the Humboldt Area Foundation, provides funds for the Children's Dental Angel Fund.

The Children's Dental Angel Fund was created in 2001 to meet dental-related needs of individual youth in Humboldt County in situations where emergency funds are required. Assistance will not be awarded for orthodontia or procedures deemed to be cosmetic in nature.

Requests must be submitted through the child's "dental home" (i.e. the primary dental provider, or a regularly attended dental clinic such as United Indian Health Services, Kima:w Medical Center, Redwoods Rural Health Center, or Burre Dental Center). Service providers may not make requests for their own reimbursement and individuals may not apply on their own behalf.

When a grant is approved, Humboldt Health Foundation will only be held responsible for the amount of funding granted at the time of consideration. Any additional treatment that is completed beyond what has been pre-approved will become the responsibility of the parent/guardian. Further requests for assistance will require additional applications to be submitted. The Children's Dental Angel Fund has a finite amount of money to award in grants each year. Grant size may be impacted by the availability of funding at the time of the request.

Please complete the attached application to make your request. An itemized pre-treatment plan from the treating dentist must be submitted along with the grant application form in order for a request to be considered. We will attempt to notify you of the status of your request within one week of receiving the application. If your request is approved, we will confirm our commitment to payment via fax with the dental office where treatment will be provided. That office will then bill us upon completion of services.

Only the last name(s) of the person in need will remain confidential.

For more information call (707) 442-2417 or email info@humhealth.org.

Guidelines for Consideration

- Recipient must be a child or youth 0-19 years of age.
- Recipient must be a current resident of Humboldt County.
- Assistance will be awarded based on financial need.
- Assistance for treatment will only be granted in circumstances in which emergency funds are needed, and
 in which there is no other identifiable source of funding available (i.e. insurance, government assistance,
 or other grant programs).
- Both the Angel and the child's parent/guardian must sign the attached Agreement Form for the request to be eligible for grant consideration.



Parent/Guardian Agreement

Please ensure that the parent or guardian of the child receiving assistance initials that they have read and understand the following agreement:

	the Children's Dental Angel Fund Program, and herby verify that my
child is eligible for assistance according to these terms.	
I understand that assistance from the Children's Dental Angel Fu emergency dental treatment for which no other sources of fundi	
I understand that the Children's Dental Angel Fund is not an insutreatment or preventative care. I agree to maintain contact with completed so that preventative care can be provided and covere	
I understand and acknowledge the importance of scheduling an amanner and of maintaining this appointment with the treating d	appointment to complete the approved treatment plan in a timely entist.
I understand that if the treatment that has been approved for grabe cancelled unless an extension of funds has been requested.	ant assistance is not completed within one year that the grant may
I understand that any dental treatment provided to my child at the treatment plan will not be covered by the Children's Dental Angel	
I agree to provide ongoing support and education to my child abo	out the importance of brushing and flossing on a daily basis.
I acknowledge that sugar sweetened food and drinks contribute	to my child's dental decay.
Parent/Guardian Signature	Date
Child's Name	Date of Birth
Angel (Advocate) Agreement	
The service provider who is advocating on behalf of the	e child for assistance should initial that they have
read and understand the following agreement:	
I understand that my role as an advocate will require me to coor will be completing the requested treatment to provide informati	dinate with the child's parent/guardian as well as the dentist who ion that is pertinent to the request for funding.
I understand that I am responsible for reporting information relative treatment as accurately as is the best of my ability. I agree to rest the application.	ated to the request, the child's financial need, and recommended spond to any follow-up questions the Foundation might have about
I agree that, once a grant has been approved through the Childre treatment is provided in a timely manner.	n's Dental Angel Fund, I will help to ensure that requested
I agree to follow up with the child's parent/guardian after treatm preventative care.	nent has been completed to discuss and schedule ongoing
Angel's Signature	 Date



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Recommendation for funds on behalf of an individual. <u>Last name</u> of person in need will be kept confidential. Form must be filled out completely and submitted by the child's dental home.

A pre-treatment plan and signed Agreement Form must be attached for consideration.

Requested by (Angel's Name):	Date:					
Position/Job Title:						
	Organization:					
Organization Mailing Address: Phone:				tate, Zip:		
Email:		Ext:	Fax:			
REQUEST						
Name:	Age & DOB:					
Family Monthly Income:		# of People in Household:				
City of Residence & Zip Code		Ethnicity:				
Insurance Provider:						
If person does not have insurance	e, why not?					
Have they applied for Medi-Cal/C	Care, etc.?					
Describe dental issues for this child and impediments to care:						
How long has child has child been	n dealing with iden	tified dental iss	ues (chronicity)?			
Present dental provider:						
Please explain why the above dentist is unable to perform						
requested procedure(s)?						
Dentist to perform requested procedure(s):						
How will dental service delivery be assured?						
Amount Requested:						
Forward Requests to: Humb		ndation		ımhealth.org		
	dianola Road			2-2417 office		
Baysiu	le, CA 95524		(/0/) 44	2-2382 fax		
Please do not write below this line. For office use only.						
Action: D	0ate:					
Am	ount:	Fun	d ID:			
Payee:		Proj	file #:			
			nt #:			