SASKATCHEWAN
ORAL HEALTH
COALITION INC.

APPLICATION TO REQUEST FUNDING FOR DENTAL TREATMENT

Complete all information, sign, and email to: sohcadmin@saskohc.ca

NAME OF APPLICANT: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY/PROVINCE: _____ **POSTAL CODE:** _____

PHONE NUMBER: _____ **EMAIL ADDRESS:** _____

Please answer the following questions:

1. **What is your reason for submitting this application?** (check all that apply)

   ☐ pain ☐ infection ☐ swelling
   ☐ difficulty speaking ☐ sleep affected ☐ do not smile
   ☐ no ability to pay ☐ no dental coverage ☐ other, describe:

2. **Describe what you have done to deal with your oral health problem:**

3. **List the names of dentists and clinics that you have been to:**

I give consent to **Saskatchewan Oral Health Coalition** to contact the above mentioned dentist/clinic to obtain oral health information for:

☐ myself and/or

☐ my child or dependent, or other individual not able to provide consent

_____ (**print** name clearly)

Signature below must be that of applicant, or in the case of a minor or other individual not able to give consent, the parent or guardian, or the substitute decision maker as applicable.

Name (print): _____

Signature: _____ **Date**: _____

The SOHC Inc. serves as a collaborative, inter-disciplinary group that addresses the needs of vulnerable populations to improve the oral health and overall health of Saskatchewan people.