Sonoma County Children's Village Legacy Fund
Orthodontic & Dental Services for Foster Youth
Program Request Form

Date ___________________ Requestor's name ____________________________________

Requestor email __________________________Requestor phone ______________________________

Requestor's relationship to child ____

Child's Name ____ Date of Birth ________________

Is the child a current/former Sonoma County Foster Youth? Yes ☐ No ☐

Is the child covered by private insurance? Yes No

*If Yes, provide proof of denial from private insurance (attach documentation) ***Required**

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Amount Requested ______________ *Payments will be made directly to the Orthodontist

Pay to: Name ____ Phone ____________________

Address ____

Reason for Request ____

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Other relevant information

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Caregiver Name ____________________________________ Phone _________________
Email____

By signing this form, I acknowledge this child has or had an open case in Sonoma County and I authorize representatives from TLC Child & Family Services to contact the service provider to facilitate payment or other logistics specifically related to this request on behalf of this youth.

Caregiver/Social Worker Signature ____

Mail completed forms to: TLC Child & Family Services or email to: legacy@tlc4kids.org
P.O. Box 2079
Sebastopol, CA 95472

For questions call (707)823-7300 or email: legacy@tlc4kids.org