

APPLICATION CHECKLIST

<input type="checkbox"/>	Application – Completed, as directed in black ink	<input type="checkbox"/>	Dental Referral Form
<input type="checkbox"/>	Contract – Read and signed by parent(s) and applicant	<input type="checkbox"/>	Report Card
<input type="checkbox"/>	Applicant Questionnaire – Handwritten by the applicant	<input type="checkbox"/>	
<input type="checkbox"/>	Household Information – Complete and accurate	<input type="checkbox"/>	
<input type="checkbox"/>	2 Letters Of Recommendation – Letters from at least two community leaders or teachers, with contact information attached		
<input type="checkbox"/>	2 Photos – Close up photos of applicant’s teeth while smiling. (1) photo, teeth showing from the front and (1) photo of the teeth from the side.		

IT IS YOUR RESPONSIBILITY TO ENSURE ALL DOCUMENTS ARE INCLUDED. WE WILL NOT NOTIFY YOU IF YOUR PACKET IS INCOMPLETE!

ORTHODONTIC SCHOLARSHIP

Smile for a Lifetime (S4L) is an international program that provides orthodontic scholarships (free braces) to children ages 11-17 who normally would not be able to afford treatment. Dr. Miller has formed a local chapter to serve children in Keene, NH/Brattleboro, VT. There is no cost to those chosen to receive an S4L orthodontic scholarship.

Scholars are chosen by a local board of directors and the process is competitive. **Scholarships are limited** and based on financial need, orthodontic need, and a complete and accurate application.

QUALIFICATIONS

- Applicant must reside in WINDHAM of VERMONT or CHESHIRE of NEW HAMPSHIRE.
- Family income of no more than (185%) of the federal poverty level. (Income eligibility form attached)*
- **If Chosen**, proof of income will be **required** to verify eligibility prior to treatment. W-2, Income tax return, SSI award letter, TANF grant letter etc.
- Applicant must be between the ages of 11 – 17.
- Have “good” dental hygiene practices and had a dental hygiene check-up in the past 6 months.
- Must have a functional and/or aesthetic need for braces.
- Must currently be enrolled in school.
- Must demonstrate a positive attitude.
- Must follow and abide by treatment plan set forth by the orthodontist and contract attached.
- Should demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service.
- Must have positive letters of recommendation from at least two community leaders and/or teachers.

*** Chapter may consider exceptions under the “special circumstances” clause. Please speak with an S4L representative for more information**

NOTE: If awarded, Proof of income is required prior to treatment. i.e. W-2, Income Tax Return for previous year, SSI Award Letter, Child Support, TANF grant letter, etc.

APPROVAL PROCESS

- The screening committee for the KEENE/BRATTLEBORO of Smile for a Lifetime will select applicants on an ongoing basis.
- Selection is based on the information provided within this packet (i.e. commentary, personal essay, character, and accompanying letters of recommendation), orthodontic and financial need.
- Please ensure that the packet is filled out completely and accurately. Incomplete packets will not be submitted to review board for selection process.
- If you would like to reapply, please speak with an S4L representative for further information.

ORTHODONTIC SCHOLARSHIP APPLICATION FORM

Today's Date:	Primary Dentist:
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APPLICANT INFORMATION

Applicant's Last Name:	First:	Middle:
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Applicant's Date Of Birth (MM/DD/YYYY):	Applicant's Age:	Applicant's Gender:	MALE	FEMALE
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Are you currently enrolled in school:	YES	NO	What grade are you in :	What is your GPA:
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Name of School:	Address (City, State, Zip Code):	Phone Number:	()
		Fax:	()

Are you wearing braces?	If you are over the age of 16, what are your plans over the next 3 years (Moving, College, etc.):
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Home Address:	City:	State:	Zip:	Home phone no.:	Cell phone no.:
				()	()

How did you hear about Smile for a Lifetime (please circle or write in your answer)?

Internet Search	Family	Friend	Dentist/Orthodontist	Boys & Girls Club	State Office	Other: (Please Specify)	
Television	Magazine	Radio	Newspaper	CASA	Internet Ad		
Are you a member of any of the following organizations? Circle all that apply:				BBBS	BGCA	CASA	NCOHF

There are many reasons why people get braces; please select the following that apply or feel free to add your own:

Discomfort while eating/drinking	Jaw and/or mouth pain	I look down when talking
Speech Impediment	I get teased about my teeth	I cover my mouth when I laugh
It's hard to clean my teeth well	I'm embarrassed to smile	I have a hard time sleeping/Sleep apnea

GUARDIAN INFORMATION

Guardian's Name:	Guardian's Occupation:	Guardian's Employer:	Employer phone no.:
			()
Guardian's Name:	Guardian's Occupation:	Guardian's Employer:	Employer phone no.:
			()

Have any other children in the household been treated through Smile for A Lifetime (If so, whom)?

Please explain in detail why you would like your son or daughter to be awarded an orthodontic scholarship through Smile for a Lifetime.

What is the best way to reach you?:	Phone: ()	Email:
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APPLICANT QUESTIONNAIRE

HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.*

Tell us about yourself. What do you like to do? Favorite hobbies, extracurricular activities, and the types of goals and aspirations in life. etc.

Tell us about your family. How many siblings do you have, who are they, do they live with you, what do you like to do together? etc.

Please tell us, in detail, why you would like braces and/or orthodontic treatment and how will orthodontia change your life? Etc.

If you had a chance to do a favor for another person/organization, without any expectation of being paid back, what would you do and why?

***If the minimum requirements are not met, your application will be considered incomplete and not included in selection process.**

CONTRACT

If selected from the pool of applicants by the screening committee of Smile for a Lifetime KEENE/BRATTLEBORO to receive orthodontic treatment, there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance provided, if requested, but the decision is largely subjective and based on the completeness of the application, commentary, personal essay, character and the accompanying letters of recommendation submitted with your packet. Orthodontic treatment for KEENE/BRATTLEBORO Chapter of Smile for a Lifetime will be provided by Dr. Miller and the team in his office .

By submitting and signing this application you understand and agree to the following:

- 1) I agree that appointments will be at the discretion Dr. Miller and his team
- 2) I understand that this can mean scheduling appointments during non-peak hours.
- 3) I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result.
- 4) I also understand that keeping appointments is essential to treatment success and is a requirement of accepting care from Dr. Miller.
- 5) If you must reschedule appointments, give the practice at least 24 hours' notice. If more than two appointments are missed or appointments are constantly rescheduled it will be considered out of compliance which is grounds for removal of braces and revocation of scholarship.
- 6) If you must relocate prior to the conclusion of treatment, Smile for a Lifetime will do its best to find another service provider. However, it is not guaranteed that Smile for a Lifetime will have another provider available in the area and/or can continue to provide treatment as a result.
- 6) One retainer will be provided as a part of the scholarship award, any replacements will not be covered by or Smile for a Lifetime or KEENE/BRATTLEBORO Chapter of Smile for a Lifetime.
- 7) **Direct responsibilities of the patient:**
 - a) Maintain excellent oral hygiene (tooth brushing, flossing). If unwilling to meet expectations due to medical and dental health risks, treatment will be discontinued.
 - b) Follow the rules for eating habits. This will greatly reduce breakage of appliances (i.e. braces) and it is necessary for satisfactory completion of treatment.
 - c) Cooperate. More than two (2) loose brackets may be deemed sufficient evidence that cooperation is not sufficient to meet minimal requirements for treatment.
 - d) Other cooperation issues are with failure to cooperate with maintenance of auxiliaries including elastics, wearing head gear, and springs.
 - e) Attitude. You will be expected to maintain an exceptionally appreciative and respectful attitude once accepted into orthodontic treatment or any other aspect of treatment supported by Dr. Miller or Smile for a Lifetime. Rude behavior or an inappreciative attitude is unacceptable.
- 8) **ATTENTION:** Failure to fulfill your responsibilities may result in removal of orthodontic equipment and discontinuation of treatment **Applicant Initials:** _____
- 9) **ATTENTION:** Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program. Future applications will not be considered. There are many deserving children who are in need of orthodontics, we are here to serve those in greatest need. **Guardian's Initials:** _____
- 10) **Media Disclaimer:** If your child is the chosen applicant, you consent to Smile for a Lifetime's (S4L) use, without charge, of all photos, video and audio recordings of your child. S4L may,
 - a) Copyright, broadcast, display, publish, re-publish and reproduce your child's image, voice and any statements made by him/her, in whole or in part, in any and all media forms; and
 - b) Assign your child a fictitious name or use his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with S4L for fundraising or other promotional and advertising purposes. You and your child also agree to participate in surveys and case management during and after receiving treatment.

Legal Guardian Consent: I certify that I am the legal guardian of the child listed on this application. I have all rights and authority to make medical decisions for the child, that all information in this application is true and correct.

This scholarship is intended specifically for underserved and deserving children in the community. There are many children who need and deserve an award winning smile and while we do our best to serve those greatest in need, it is a competitive process and not everyone will receive a scholarship.

Please take your time on your application; your time and effort will be taken into consideration when selecting applicants for scholarships.

Applicant's Name (Printed First, MI, Last)	Applicant's Signature	Date
Guardian's Name (Printed First, MI, Last)	Guardian's Signature	Date
Guardian's Name (Printed First, MI, Last)	Guardian's Signature	Date



DENTAL REFERRAL FORM

Dear Dental Care Provider,

Your patient is applying for an orthodontic scholarship. *If selected*, the patient will receive free braces through the Smile for a Lifetime Foundation. As the child's dental care provider, it is very important we receive feedback from you in regards to your patient so we can determine whether or not they will be a good candidate for our program. If the form is incomplete, the application cannot be included in the selection process.

To be filled out by the applicant's dentist. This form is to be completed prior to submitting application.

Patient Name:

	Last	First	
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Dentist's Name:

	Last	Last	First	First	Middle	Middle
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Dentist's Address:

	Street	City	State	Zip Code
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Dentist's Contact info:

	Office Phone Number	Alternate Number	Email address
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General Information:

Does the patient need restorative work at this time? Please circle one.	Yes	No
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Does the patient have good oral hygiene?	Yes	No
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Impacted Teeth:	Yes	No
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Other Functional or Aesthetic Issues/ Additional Comments:

How long have you been treating the patient:

Does the patient have a positive and respectful attitude:

Does the patient keep appointments: (please circle one)	Never	Rarely	Sometimes	Mostly	Always
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Dentist's Signature Date

