smileschangelives®

Application and Guidelines

Following is the application to receive orthodontic treatment through SCL. Fully complete this application and return it to SCL with all attachments; your application **must** include a dental referral form (enclosed) filled out an signed by your dentist, a copy of your most recent tax return and/or Social Security benefit awards letter(s), and a *$25 non-refundable application fee.* **See notes in the financial section for tax return requirements. Please notify SCL if the applicant moves or if any contact information changes!**

A. This is a competitive program. The demand for our program often exceeds our ability to fulfill all requests. We recommend including letters of support from family, teachers and/or community members, and a personal essay about why the applicant would benefit from braces.

B. Once the complete application packet is reviewed, applicants will be scheduled for an SCL-sponsored orthodontic screening on a first-come, first-served basis. The wait for a screening appointment can take from 2-12 months, depending on area demand. When it is the applicant's turn, he or she will receive a letter stating when, where and how to schedule their screening appointment.

C. After screening, the applicant's case is reviewed by an orthodontic review panel. Based on the panel's decision, SCL notifies the family if their application was accepted or declined, or if there is a need for rescreening due to poor oral hygiene, further dental development, or other issues.

D. If accepted, the family must submit the program fee* to SCL within 90 days. Once the payment is received, the child is assigned to an area partner orthodontist.

Program Qualifications

- Be age 11-18 and have good oral hygiene (including regular dental visits, cleanings and no cavities). The applicant's dental referral form confirms the applicant's good oral hygiene. The dental referral form **must be dated** within 6 months of date of application. Applicants who are already wearing braces are ineligible for the program.
- Need orthodontic treatment that can be delivered as a one-stage process. Our program covers orthodontics only; any cleanings, fillings, extraction or surgical needs are the family's financial responsibility.
- Agree to pay $500 toward participation in the program.* This program is for families with documented financial need. Income guidelines can be found at www.smileschangelives.org/qualify.
- Agree to follow program rules as outlined on the enclosed form. Each item must be initialed and both the parent/custodian and the child must sign the form.

Please submit the completed application with all requested documents attached, including the $25 non-refundable application fee (personal checks, cashier's checks or money orders are accepted) to SCL National Headquarters at the address below. For non-parental custodians, submit a copy of the authorization to make medical decisions. For children in state custody, submit a copy of their state medical consent documentation. For questions, email applicant@smileschangelives.org or call the number below.

**A limited number of partially subsidized placements may be available in some areas. Visit our website at www.smileschangelives.org/qualify for current information.*

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SCL Application (Applicant Portion)

I. PERSONAL (to be completed by the applicant) **Today's Date_______________**

Applicant Last Name	Applicant First Name	M.I.	Date of Birth

Street Address/P.O. Box	City	State	ZIP	County

Sex	Race/Ethnicity	Phone Number	Email

Name of School	Grade	School City	School State

Grade Point Average	Hobbies/Interests

Please describe why you want orthodontic treatment: ________________________________

____

How did you become aware that you needed braces?

____

Below are some of the reasons why people get braces. Circle the ones that apply to you.

I am embarrassed how my teeth look.	A little	A lot	Not at all
I have difficulty eating and/or drinking.	A little	A lot	Not at all
I have pain in my mouth and/or jaw.	A little	A lot	Not at all
People make fun of my teeth.	A little	A lot	Not at all
I have difficulty talking.	A little	A lot	Not at all
I'm afraid to smile.	A little	A lot	Not at all
I cannot clean my teeth very well.	A little	A lot	Not at all
I cover my mouth when I talk or smile.	A little	A lot	Not at all

If anyone has ever made fun of your mouth or teeth, please give us examples of what people have said:

____

How do you think your life will change once you get braces? __________________________

____

What are your plans for the next 2-3 years? Are you planning to move away from your current area?

____

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SCL Application (Parent/Guardian Portion)

____ ______________ ________________
Parent/Guardian Last Name, First Name Home Phone Cell/Work Phone

____ _____________________
Street Address City State ZIP Email

Applicant Lives With: _______________________ Relationship to Applicant: _____________________

Marital Status: ______________________ Spouse/Partner's Name: ___________________________

How did you hear about Smiles Change Lives? Circle all that apply.

Search Engine ____________________
TV/Radio ________________________
Dentist __________________________
Orthodontist _____________________
Other ___________________________

Newspaper/Magazine ___________________________
Dental School/Clinic ___________________________
School Nurse/Counselor _________________________
Family Member/Friend __________________________

II. FINANCIAL

Please note: Acceptance into the program requires each approved applicant to pay $500 toward participation in our program. If approved, you will have 90 days from notification to make this payment to SCL.

Are you willing to pay $500* for participation in our program? Please circle one: yes no

Are you currently employed? Yes No Employer: ____________________ Phone Number: _______

Is your spouse/partner currently employed? Yes No Employer: _____________________________

How many people in applicant's household? _____ Family income from ALL sources per year: ___________

You must submit your most recent IRS tax return or copy of your SSI benefit awards letter(s). If the applicant is not claimed on the tax return, please explain why. In this case, submit the tax return for where the child lives and include proof that the child is living at the address (e.g. school records). For non-parental guardians, please submit a copy of your medical authorization. For children in state custody, please submit a copy of their state medical consent documentation.

If you do not file income taxes or receive SSI benefits, your application cannot be reviewed.

**A limited number of partially subsidized placements may be available in some areas. Visit our website at www.smileschangelives.org/qualify for current information. If you are accepted into the program and do not receive a partially subsidized placement, you may choose to pay $500 or withdraw from the program.*

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SCL Application (Parent/Guardian continued)

III. INSURANCE INFORMATION

Is the applicant covered by dental insurance (other than Medicaid)? If no, skip to Section IV: Yes No

Is there an orthodontic benefit? If no, skip to Section IV: Yes No

______________________	______________________	______________
Name of Carrier	Amount of Coverage	ID Number

IV. GENERAL INFORMATION

Do you own or rent your home? ______________________

Is the applicant currently wearing braces? Circle one: Yes No

Have any of the applicant's family members been treated through the SCL program? If yes, please list their name(s): ______________________

How will the applicant get to his/her orthodontic appointments? ______________________

Please list any health problems or issues which would make it difficult for the applicant to participate in treatment: ______________________

Why do you want your child to receive orthodontic treatment? ______________________

____

Any other information about the applicant you wish to bring to the attention of the Community Advisory Board

____

____

____

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PROGRAM RULES AND GUIDELINES

This opportunity for your child to receive braces through SCL is one that many children do not receive, and we are very happy to help make this possible. However, we only provide treatment if you and your child fully cooperate with the treatment plan and the treating orthodontist. All the following conditions must be met to be eligible.
PLEASE READ CAREFULLY AND INITIAL EACH ITEM:

_________ Smiles Change Lives (SCL), a program of the Virginia Brown Community Orthodontic Partnership, provides for orthodontic treatment ONLY. Extractions, cleanings, oral surgery or other treatment that may be necessary before, during or after orthodontic treatment at the financial responsibility of the participant's parents or legal guardians.

_________ If your child has cavities or periodontal disease, these conditions must me completely remedied before treatment is started

_________ Your child must be seen by a dentist within six (6) months of the date on this application. Your child's dentist must complete the Dental Referral Form and indicate that all necessary treatment has been completed before braces will be applied. Your child must have regular dental visits and cleanings at least every six months during orthodontic treatment.

_________ During the course of treatment, if you child's teeth are not cleaned properly, cavities can form around the braces. If your child does not keep his or her mouth clean, or if cavities form and are not remedied, the orthodontist has the option to remove the braces and end treatment. Your child will them be dismissed from the program.

_________ If accepted, the parents/legal guardians of the participant must pay a fee of $500* to SCL within 90 days of notice.

_________ If accepted, SCL will assign your child to a private orthodontists or an area dental school for treatment. Treatment is only available from the assigned orthodontists. If you move away from the area, SCL will attempt to help you find a doctor in you new area, however SCL cannot guarantee this will be possible. If you leave the area before treatment concludes and SCL cannot arrange a new doctor, you must advise your orthodontist and make any arrangements necessary to complete treatment, including finding a new orthodontist – which become your financial responsibility – or having the braces removed by the current orthodontist.

_________ Regular orthodontic appointments are required to make sure teeth move as expected and no unwanted movement occurs. It is your responsibility to make sure that all scheduled appointments are kept. Failure to meet this obligation of attending appointments on a regular basis is grounds for the orthodontist to remove the braces and end treatment.

_________ You and your child must fully follow the treatment plan set by your orthodontist, which will be explained to you before treatment starts. If you fail to follow the treatment plan, the treating orthodontist had the option to refuse to continue treatment, to remove the braces and to end treatment.

_________ During the course of treatment, your child must cooperate with the assigned orthodontist. Failure to fully cooperate with the orthodontist, or to maintain proper behavior so that the treatment can be delivered, can result in the orthodontist refusing to continue treatment until the behavior problem is corrected or removing the braces.

_________ Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to braces, the orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by SCL.

_________ One (1) retainer device will be provided as part of the treatment program at no charge. If this retainer is lost or damaged, you will be charged for a replacement.

_________ If treatment is approved, we have your consent to use your child's name, case history, photos and quotes for fundraising and/or other promotional/business purposes.

_________ You and your child agree to participate in survey and case management during and after orthodontic treatment.

**A limited number of partially subsidized placements may be available in some areas. Visit our website, www.smileschangelives.org/qualify for current information. If you are accepted into the program and do not receive a partially subsidized placement, you may choose to pay $500 or withdraw from the program.*

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Consent and Hold Harmless Agreement

The undersigned being the **Custodial Parent or Legal Guardian** of the applicant has read and/or understands the information setting forth all of the Rules and Guidelines to receive orthodontic treatment through **Smiles Change Lives**. I have been given the opportunity to ask questions about this information. I understand that acceptance into the Smiles Change Lives program for my child's orthodontic care is based on our (parent and child) ability to maintain our child's dental health as indicated above and to abide by all the Rules and Guidelines. **I also understand that if our ability or desire to maintain dental health or to abide by these Rules and Guidelines is not met as indicated above, the braces will be removed and treatment will be terminated with no refund**. I further consent and agree that if treatment is stopped and my child is removed from the program for not following the **Rules and Guidelines**, we (my child and I) will hold harmless and free from any liability to **Smiles Change Lives** and the treating orthodontist for any damage or injury resulting from the termination of said treatment. If our application is approved, I consent to allow **Smiles Change Lives** and its partner doctors to provide orthodontic treatment for my child.

I, on behalf of myself and my child, acknowledge that Smiles Change Lives does not itself administer and orthodontic treatment and that all treatment will be provided by an assigned orthodontist. In consideration of the acceptance of my child's application to Smiles Change Lives, we (my child and I) release Smiles Change Lives, the treating orthodontist and their agents, representatives, and successor from any and all claims, demands, actions, proceedings or liability of any kind whatsoever that we may have at any time relating to our participation with Smiles Change Lives. I expressly agree that this agreement is intended to be as a broad and inclusive as permitted by the laws of the State of Missouri and any other state where such activities may occur, and that if any portion of this agreement is help invalid, the remainder of it shall remain effective.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND VOLUNTARILY AGREE TO THE ABOVE.

Custodial Parent or Legal Guardian Consent

Date (mm/dd/yyyy)	Custodial Parent or Legal Guardian Signature	Printed Name

Applicant Consent (The applicant named below is the previously designated recipient of treatment through Smiles Change Lives and also agrees to be bound by the above Consent and Hold Harmless Agreement)

Date (mm/dd/yyyy)	Applicant Signature	Printed Name

Return the completed application along with your $25 application fee to the following address:

Smiles Change Lives
Program Coordinator
2405 Grand, Suite 300
Kansas City, MO 64108

Please ensure you use adequate postage. If you have questions, please email us at applicant@smileschangelives.org, or call us at the following numbers: (888) 900-3554 or (816) 421-4949.
Keep a copy of your completed applications for your records.

Note: Incomplete applications or applications submitted without the $25 application fee will not be accepted. Use the checklist on the following page to ensure your application is complete.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members, volunteers, agents or disclosed to other health care professionals for the purpose of evaluating and providing your treatment.

Program Operations: Patient information, including first name, case history and photographic images may be used as necessary to support assessment, public relations, fund development and/or other activities of **Smiles Change Lives**.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for and purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you noticed us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include: ▪ The right to request restrictions on the use and disclosure of your protected health information ▪ The right to inspect and copy your protected health information ▪ The right to amend or submit corrections to your protected health information ▪ The right to receive an accounting of how and to whom your protected health information has been disclosed ▪ The right to receive a printed copy of this notice.

Smiles Change Lives Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting LeAnn Smith at the address below.

Complaints contact Person: If you would like to submit a comment or have questions regarding our privacy practices, you may contact us in writing at the following address: LeAnn Smith, Smiles Change Lives, 2405 Grand, Suite 300, Kansas City, MO 64108

If you believe that your privacy rights have been violated, you should call the matter to our attention in writing to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after **05/01/2005**

I, ______________________________ have received a copy of Smiles Change Lives' Privacy Practices.
Printed Name

______________________________ ______________
Signature Date (mm/dd/yyyy)

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Checklist for Applicant Families

Did you:

- □ Fill out your application completely?
- □ Include a copy of your most recent federal tax return (1040 form) or Social Security income benefits letter?
  - * If your child is not claimed on your tax return, did you explain why?
  - * If you share a joint custody, please include both parents' tax returns or SSI letters
  - * If you alternate claiming your child, please include both parents' tax returns
- □ Include a completed Dental Referral Form from a visit within the past 6 months? (See page 9)
- □ Include a copy of your Medicaid authorization/medical consent if you are not the applicant's parental guardian? (If the applicant is in state custody, please include a copy of the state medical consent documentation.)

  _____ Check here if the child is in state custody.
- □ Check the box indicating that you are willing to pay $500* toward participation in our program if your child is accepted? (See page 3, Section II: Financial)
- □ Check the box whether or not your child is currently wearing braces? (See Page 4, Section IV: General Information)
- □ Initial each item on the Program Rules and Guidelines form? (See page 5)
- □ Sign the consent form (See page 6)
- □ Have your child sign the consent form? (See page 6) [Even though a minor, we require your child's signature]
- □ Sign and include the Notice of Privacy Practices form? (See page 7)
- □ Retain a copy of your compete application for your records?
- □ Optional (but strongly encouraged): Did you include any personal letters, essays or letters of support for your application?
- □ Include your non-refundable $25 application fee, made out to Smiles Change Lives?

If any of these required items are missing, your application will be declined upon receipt. You may reapply at any time by submitting a new application.

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DENTAL REFERRAL FORM

(Must be filled out by your general dentist)

Date of today's or most recent visit – must be within 6 months of application:___________________

Patient Name____
(First) (MI) (Last)

Patient Address: ____
(Street) (City) (State) (ZIP Code)

Dentist Name: ____
(First) (Last)

Dentist Address: ____
(Street) (City) (State) (ZIP Code)

Dentist Phone Number*: _________________________ **Date of 1st Office Visit:** __________________
**Important for verification purposes*

Functional:

Malocclusion:	☐ Class I	☐ Class II	☐ Class III	
Crowding:	☐ Mild ≤ 3mm	☐ Moderate 4-6mm	☐ Severe ≥ 7mm	
Spacing:	☐ Mild ≤ 3mm	☐ Moderate 4-6mm	☐ Severe ≥ 7mm	
Overjet:	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 5mm	
Overbite:	☐ Normal	☐ Moderate (50-75%)	☐ Severe > 75%	☐ Open bite
Crossbite:	☐ None	☐ Anterior	☐ Posterior	
Misalignment:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Good Oral Hygiene: ☐ Yes ☐ No (plaque, inflamed gingival tissue)		**Caries Free:** ☐ Yes ☐ No	**Physically capable of cleaning teeth:** ☐ Yes ☐ No	
Positive attitude toward dental care: ☐ Yes ☐ No		**Keeps appointments:** ☐ Yes ☐ No	**Patient motivated/interested in orthodontic treatment:** ☐ Yes ☐ No	
Impacted teeth: ☐ Yes ☐ No	**Missing Teeth:** ☐ Yes ☐ No	**Have second molars erupted?** ☐ Yes ☐ No	**Number of deciduous teeth present:** __________	

Other Functional or Aesthetic Problems/Comments:

_______________________________________ _______________________________________
Referring Dentist Signature Date Signed
(Please attach a business card for verification)

PLEASE INCLUDE THIS COMPLETED FORM WITH YOUR APPLICATION PACKAGE

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