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Smiles Change Lives Program Qualification and Guidelines

To qualify for Smiles Change Lives:

- Applicants must be 11-18 years old, have good oral hygiene, not wearing braces and must be motivated to receive orthodontic treatment that can be delivered as a one-stage process. Our program covers orthodontics only. Any cleanings, fillings, extractions or surgical needs are the family's financial responsibility.
- Submit a signed Dental Referral Form (DRF) (page 7) from an appointment within the past 6 months.
- The family taxable income must be at or below 200% of the Federal Poverty Level, per the most recent federal tax return (1040 form, not W-2). *If you do not file taxes but receive SSI benefits, please submit a copy of your most recent awards letter.* **Please visit www.smileschangelives.org/qualify for our income guidelines.**
- The applicant and parent/guardian must agree to follow all program rules and guidelines, as stated on page 5. If approved, the family agrees to pay $500* to participate in the program.
- SCL coordinates all communication between applicants and our provider orthodontists. **Please do not contact a provider unless instructed to do so by SCL. If you contact a provider without the permission of SCL, the applicant may be removed from the program.**

How the application and approval process works:

1. After receiving a fully completed application with all required documents, SCL staff will review it to determine if the applicant qualifies for the program. If the applicant doesn't qualify, they will be notified by letter.
2. If the applicant qualifies for the program, he or she will be notified to schedule an orthodontic screening. The waiting period for a screening can take from 1-12 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 the screening appointment.
3. After the screening, each 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 because of poor oral hygiene, further dental development or other issues.
4. If accepted, the family must submit the program fee* to SCL within 90 days. Once the payment is received, the child will be assigned to an SCL orthodontic provider.

Please submit the fully completed application with the following documentation to SCL:

- ☐ $25 non-refundable application fee (personal checks, money orders, or cashier's checks are accepted).
- ☐ Most recent federal tax form (1040, not W-2) or SSI awards letter. *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 card and medical consent.*
  - 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.
- ☐ Dental Referral Form (page 7) completed by a dentist, based on a visit within the last 6 months.
- ☐ Signed consent form – both parent/guardian and child must sign (page 6).
- ☐ Signed Notice of Privacy Practices form (page 4).
- ☐ Personal essay, letters of support or pictures (optional, but recommended).

If any of these required items are missing, your application will be declined upon receipt. Your application will be reconsidered by submitting the required documentation.

How did you hear about Smiles Change Lives? Please circle and name all that apply.

Internet/Search Engine _____ Newspaper/Magazine _____
TV/Radio _____ Dental School/Clinic _____
Dentist _____ School Nurse/Counselor _____
Orthodontist _____ Family/Friend/Other _____

Applications are available in English and Spanish, and are available at www.smileschangelives.org/apply. If you have any questions, please call toll-free (888) 900-3554 or email applicant@smileschangelives.org.

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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Applicant Portion (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 | Grade

_____ _____ _____ _____
Name of School | School City | State | Grade Point Avg.

_____
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. Select the ones that apply to you.

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

_____

If you are over 17, 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 Phone

_____ _____

Street Address City State ZIP Email

Applicant Lives With: _____ Relationship to Applicant: _____

Marital Status: _____ Spouse/Partner's Name: _____

II. FINANCIAL – Acceptance into the program requires approved applicants 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: _____

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

Do you own or rent your home? _____ Number of years at this address: _____

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 your tax return, please explain why and submit the tax return for where the child lives with proof the child is living at that 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 card and consent. If you do not file income taxes or receive SSI benefits, your application will not be approved.

III. GENERAL INFORMATION Is the applicant currently wearing braces? Circle one: Yes No

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

_____

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

Please list any health issues we should be aware of: _____

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 Review Panel?

_____

_____

III. INSURANCE INFORMATION Is the applicant covered by Medicaid? Yes No

Is the applicant covered by dental insurance? Yes No Is there an orthodontic benefit? Yes No

_____ _____ _____

Name of Carrier Amount of Coverage ID Number

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL 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 – Effective Date: This notice is effective on or after 05/01/2005.

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 Jones Foundation/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.

Jones Foundation/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.

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

_____ _____
Signature Date (mm/dd/yyyy)

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Program Rules and Guidelines

This opportunity for your child to receive braces through Smiles Change Lives 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 are the financial responsibility of the participant's parents or legal guardians.

_____ If your child has cavities or periodontal disease, these conditions must be 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, your child will be assigned to an orthodontist for treatment. Treatment is only available from the assigned orthodontist. If you move away from the area before treatment concludes, 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 this program.

_____ 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, without charge, your child's name, case history, photos and quotes for fundraising and/or other promotional/business purposes and you expressly agree to waive any benefit derived from such use.

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

_____ Smiles Change Lives coordinates all communication between applicants and our provider orthodontists. Please do not contact a provider unless instructed to do so by SCL. If you contact a provider without the permission of SCL, your child may be removed from the program.

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 **Program Rules and Guidelines** for receiving 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 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 the orthodontic treatment and that all treatment will be provided by an assigned orthodontist ("partner doctor"). In consideration of the acceptance of my child's application to Smiles Change Lives, we (my child and I) release Smiles Change Lives, the partner doctor and their agents, representatives, and successors from any and all claims, demands, actions, proceedings or liability of any kind whatsoever that we may have at any time arising, directly or indirectly, from (i) our participation with Smiles Change Lives, or (ii) any action taken by Smiles Change Lives in connection with the Program Rules and Guidelines. This Agreement shall be interpreted and enforced in accordance with the laws of Missouri and is intended to be as broad and inclusive as permitted by the laws therein or any other state where such activities may occur. This agreement shall survive termination or completion of my child's treatment. If any portion of this agreement is held 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: I certify that all the information enclosed in this packet is true and correct and that all income is reported. I understand that deliberate misrepresentation will not be tolerated and will result in dismal from the program. *Your signature must be hand written. Electronic signatures are not acceptable*.

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 *(Not Parent/Guardian)*	Printed Name

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

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

Note: Incomplete applications and applications submitted without the $25 application fee will not be accepted. Use the checklist on the first page to ensure your application is complete. Please ensure you use adequate postage and keep a copy of your completed application for your records.

If you have questions, please email us at applicant@smileschangelives.org, or call us at: (888) 900-3554 or (816) 421-4949.

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DENTAL REFERRAL FORM - Must be completed by your general dentist

Date of todays 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:_____

_____

Does this patient need restorative work at this time? ☐ Yes ☐ No

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

PLEASE INCLUDE THIS COMPLETED FORM WITH YOUR APPLICATION PACKAGE