



Smiles Change Lives

Program Guidelines and Application

Smiles Change Lives (SCL) is happy to provide this **once in a lifetime opportunity** for your child to receive braces.

QUALIFICATIONS: Your child must meet ALL qualifications to apply to the program.

- Be 10-18 years of age;
- Have no more than four (4) baby teeth; *if you need more information on how many baby teeth your child still has, please ask your child's dentist.*
- Have "good" dental hygiene (*as certified by the child's general dentist*);
- Have no unfilled cavities;
- Not be wearing braces currently; and
- Have a total household income at or below 200% of the Federal Poverty Level
 - 200% of the Federal Poverty Level can be determined by visiting <http://www.smileschangelives.org/financial>
- Be willing to pay the **\$30 (USD)** application fee and the **\$600 (USD)** program administration fee (per child).

APPLICATION AND APPROVAL PROCESS:

- Upon receipt of a **COMPLETE** application, the application will be reviewed and the family will be notified whether or not the child qualifies for the next step in the application process. **If your application is INCOMPLETE**, it will be returned to you and in order to be considered for the program, **you will be required to submit a NEW complete application, including an additional \$30 non-refundable fee.**
- If your child qualifies for the program, SCL will work to assign the child with a provider to perform a screening. The waiting period for this step of the program varies and can be longer than twelve (12) months based on area demand. For estimated wait times in your area visit: <http://www.smileschangelives.org/waitinglist>. When a screening provider becomes available, the family will receive a letter indicating when, where and how to schedule the screening appointment (*the screening provider may or may not be the same provider to treat your child if your child is accepted for treatment*).
- Once SCL has received the screening information, it will be reviewed by the SCL Review Panel and the family will be notified whether the child (i) is approved for the program, (ii) is declined for the program, or (iii) will need to be re-screened (due to poor dental hygiene, dental development, or other potential issues).
- If there are no treatment openings in your area at the time of approval, you will be notified that you have been approved and that we are working to identify a treatment provider (*who may be different than the screening provider*) in your area for your child. The waiting period for this step of the program varies and can be longer than twelve (12) months based on area demand. Likewise, treatment providers are limited in some areas, and SCL cannot make any guarantees of placement.
- Once a treatment provider is identified for your child, you will be notified and **will have 30 days in which to pay the \$600 (USD) program administration fee.** We cannot accept partial payments. If this fee is not received by SCL in full within 30 days of notification, your child will lose his/her provider placement and will be returned to the waiting list until another treatment provider has an opening.
- This program fee is your investment in your child's beautiful new smile. Likewise, when you pay the fee, you know that not only will your child benefit, but that you are also "paying it forward" to help the program be available to assist other families in the future.
- If the payment is received within 30 days, your child will be assigned to an SCL treatment provider and will be on their way to a healthy, happy smile!



APPLICATION CHECKLIST
(must be signed and included with submitted application)

All of the items below must be fully completed and submitted to SCL for EACH child that is applying to the program. Use the checklist to indicate that you have included each required document; that each has been fully completed; and that all items are signed where required. **If your application is INCOMPLETE, it will be returned to you and in order to be considered for the program, you will be required to submit a NEW complete application, including an additional \$30 non-refundable fee.**

- \$30.00 (USD) non-refundable application fee** (check or money order; payable to Smiles Change Lives)
- Child's Application** (pg 3)
- Parent/Guardian Application** (pg 4)
- Notice of Privacy Practices** (pg. 5 – MUST be signed by parent/guardian)
- Program Rules and Guidelines** (pgs. 6 - All items MUST be *initialed* by parent/guardian)
- Parent/Legal Guardian Consent & Child Consent** (pg. 7–MUST be signed by BOTH parent/guardian & child)
- Dental Referral Form** (pgs. 9-10 - Must be FULLY completed by child's dentist or dental hygienist based on an exam no more than 6 months prior to the application date and show good dental hygiene and no unfilled cavities)
- Federal Tax Form 1040/SSI Awards Letter:** Proof of income MUST be submitted in the form of either a COMPLETE copy of the most recent year's federal tax return (include ALL pages, schedules or statements) AND/OR a copy of a current SSI awards letter. Tax forms/SSI awards letters that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted. If you are submitting applications for more than one child, you MUST include a copy of your tax form/SSI Awards letter with EACH application.**
If submitting Form 1040/1040A, please note:
 - o The child applying MUST be listed as a dependent on either page one of Form 1040/1040A or on Statement 1 along with the child's Social Security number.
 - o If the child is NOT claimed as a dependent on your tax return, you must explain why and ALSO submit the tax return for the person who DOES claim the child, as well as proof of where the child resides (e.g. school records). In this situation, both tax returns must meet our income qualifications.
 - o Page two of Form 1040/1040A (line 43 on 1040 and line 27 on 1040A) must show total household income at or below 200% of the Federal Poverty Level.
 - o If your income level does not require you to file taxes, but you are legally allowed to file, you must do so in order to apply for our program, even if your income is \$0.
- Optional: **Personal essay** from the child and/or letters of support detailing why the child wants/needs braces, how they feel their life might be improved as a result of treatment, etc *(This is optional but encouraged)*

*** Additional documentation required for non-parental guardians:**

- Non-parental guardians must submit a copy of their authorization to make medical decisions.
- For children in state custody, copies of the child's state medical card and medical consent must be submitted.

Signature of parent/guardian

Mail COMPLETE application to: **Smiles Change Lives, 2405 Grand Blvd, Suite 300, Kansas City, MO 64108**
Please ensure you use adequate postage and keep a copy of your completed application for your records.



PARENT/GUARDIAN APPLICATION
(To be completed by parent/guardian; please write clearly)

I. PERSONAL INFORMATION

Parent/Guardian Last Name _____ First Name _____
Home Phone _____ Cell Phone _____ Email _____
Address _____ City _____ State _____ ZIP _____ # of years at current address _____
Marital Status: _____ Spouse/Partner's Name: _____
Spouse/Partner Phone: _____ Email: _____
Child Lives With: _____ Relationship to Child: _____

For non-parental guardians, you **MUST** submit a copy of your medical authorization. For children in state custody, submit a copy of their state medical card and consent.

Best way to communicate (check one): Email Mail

II. FINANCIAL: Qualification requires a total household income **at or below** 200% of the Federal Poverty Level.

Total Household Income: \$ _____ How many people in the child's household? _____

You **MUST** submit your most recent **Federal Tax Form 1040** and/or copy of your **SSI benefit awards letter(s)**. If you do not file income taxes or receive SSI benefits, your application will NOT be approved.

If the child is not claimed as a dependent on your tax return, you must explain why and submit the tax return for the person who claims the child, as well as proof of where the child resides (e.g. school records).

III. GENERAL INFORMATION

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

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

Please list any health issues your child has that we should be aware of: _____

IV. INSURANCE INFORMATION: *This information is **not** a factor in determining eligibility*

Is the child covered by Medicaid/State Program? Yes No

Is the child covered by dental insurance? Yes No



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

Treatment: Your protected health information may be used by staff members, volunteers, agents and national and advisory board members of the Virginia Brown Community Orthodontic Partnership d/b/a Smiles Change Lives and disclosed to other health care professionals, including but not limited to your assigned screening and treatment provider(s), for the purpose of evaluating your application 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 other activities of Smiles Change Lives.

Law enforcement: Your protected 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 protected 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 protected health information or its use for any 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 to abide by the privacy policies and practices that are outlined in this notice and to notify you when a breach of your unsecured protected health information has occurred.

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 Lisa Shepard at the address below.

Complaints Contact Person: If you would like to submit a complaint or have questions regarding our privacy practices, you may contact us in writing at the following address: Lisa Shepard, Smiles Change Lives, 2405 Grand, Suite 300, Kansas City, MO 64108 or you may contact the Secretary of Health and Human Services. 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.
Custodial Parent or Legal Guardian **PRINTED NAME**

Custodial Parent or Legal Guardian **SIGNATURE**

Date (mm/dd/yyyy)



Program Rules and Guidelines

Smiles Change Lives is happy to provide this **once-in-a-lifetime** opportunity for your child to receive braces – it is an opportunity that many children do not receive. However, we will only provide treatment if you and your child fully cooperate with the treatment provider and his/her treatment plan. All of the following conditions must be met to be eligible to start treatment and to continue treatment.

PARENT OR GUARDIAN: PLEASE READ CAREFULLY AND INITIAL EACH ITEM:

- _____ 1. 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.
- _____ 2. Your child must have been seen by a dentist within six (6) months of the date on his/her 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. If your child has cavities or periodontal disease, these conditions must be completely remedied before treatment is started.
- _____ 3. If accepted, the parents/guardians of the participant agree to submit the **\$600 (USD) program fee** upon notice from SCL. If payment is not received within **30 days** of such notice, your child will lose his/her placement to be assigned to a treatment provider and go back on a waiting list. Treatment providers are limited in some areas and SCL cannot make guarantees of placement.
- _____ 4. Once accepted and the program fee is received, your child will begin treatment with the assigned SCL treatment provider. Treatment is only available from the assigned provider, who is donating his/her time and all materials/supplies required to provide full treatment for your child. Typically, the average cost of braces NOT acquired via Smiles Change Lives is \$5,500.
- _____ 5. Regular appointments are required to make sure teeth move as expected and no unwanted movement occurs. Since the treatment provider is donating the treatment, s/he may require you to attend appointments during non-peak hours. As a result, your child's appointments will likely be scheduled during the mid-morning or mid-afternoon hours. It is your responsibility to make sure that all scheduled appointments are kept. If you must cancel or reschedule an appointment, you are required to give your doctor at least 24 hours notice. **Not calling to cancel or missing an appointment is grounds to have your child's braces removed.**
- _____ 6. You and your child must fully follow the treatment plan set by your treatment provider, which will be explained to you before treatment starts. If you fail to follow the treatment plan, the treatment provider has the option to refuse to continue treatment by removing the braces and ending treatment.
- _____ 7. If you have to move before treatment concludes, please call us in addition to telling your treatment provider. You are responsible for making any arrangements necessary to complete your child's care. Your options are to either have your current treatment provider remove the braces or you will need to find a new treatment provider in your new community. SCL is not responsible for locating a new treatment provider or paying for continued treatment.
- _____ 8. During the course of treatment, if your child's teeth are not cleaned properly, cavities can form around the braces. If your child does not keep his/her teeth, gums and mouth clean, or if cavities form and are not remedied, the treatment provider has the option to remove the braces and end treatment.
- _____ 9. During the course of treatment, your child must cooperate with the assigned treatment provider. Failure to fully cooperate with the treatment provider, or to maintain proper behavior so that the treatment can be delivered, can result in the provider's refusing to continue treatment until the behavior problem is corrected, or removing the braces.
- _____ 10. Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must not eat hard or sticky foods or pull on the braces. **If there is frequent damage to the braces, the treatment provider has the option of removing the braces or charging you to repair the damage, which is not covered by this program.**
- _____ 11. 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.**
- _____ 12. If your child is accepted into the program, you consent to SCL's use, without charge, of all photos, video or audio recordings of your child. SCL may (1) 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 (2) 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 SCL, for fundraising or other promotional and advertising purposes. You and your child agree to participate in surveys and case management during and after treatment.
- _____ 13. SCL coordinates all communication between families/children and the treatment providers. Do NOT contact a provider unless instructed by SCL. If you contact a provider without permission, your child may be removed from the program.



Consent and Hold Harmless Agreement

The undersigned has read, understands and agrees to abide by the attached **Program Rules and Guidelines**, which are incorporated herein by reference, for receiving orthodontic treatment through the Virginia Brown Community Orthodontic Partnership d/b/a **Smiles Change Lives**, and has been given the opportunity to ask questions about this information. If our application is approved, I consent to allow Smiles Change Lives and its partner doctors to provide orthodontic treatment for my child. I understand that acceptance into the Smiles Change Lives program for my child's orthodontic care is based on our (my child's and my) ability to maintain my child's dental health as indicated in the Program Rules and Guidelines and to abide by all the Program Rules and Guidelines. **I also understand that if we do not maintain dental health and abide by the Program Rules and Guidelines, the braces will be removed and treatment will be terminated with no refund.** I further agree that if treatment is stopped and my child is removed from the program for not following the Rules and Guidelines, or for any other reason, we (my child and I) will hold Smiles Change Lives and the assigned treatment provider harmless and free from any liability for any damage or injury resulting from the termination of said treatment.

I, on behalf of myself and my child, acknowledge that Smiles Change Lives does not itself provide the orthodontic treatment and that all treatment will be provided by a doctor assigned by Smiles Change Lives ("partner doctor"). In consideration of the acceptance of my child's application by 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 in the Smiles Change Lives program, or (ii) any action taken by Smiles Change Lives or the partner doctor based on the Program Rules and Guidelines. I further acknowledge and understand that SCL and the partner doctor do not guarantee satisfaction with the outcome of the orthodontic treatment provided. 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 thereof or of any other state where Smiles Change Lives program activities occur. Waiver of any provision by Smiles Change Lives shall not operate or be construed as a continuing waiver. 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, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE CONSENT AND HOLD HARMLESS AGREEMENT.

Custodial Parent or Legal Guardian Consent: I further certify I am the custodial parent or legal guardian for the child named below, that I have legal authority to make medical decisions for the child, that all the information enclosed in this application is true and correct and that all income is reported. I understand that deliberate misrepresentation will not be tolerated and will result in dismissal 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

Child Consent: (Child MUST sign even if under 18 years of age)

Date (mm/dd/yyyy) Child/Applicant SIGNATURE (Not Parent/Guardian) PRINTED NAME

This page was intentionally left blank.
Please continue to the next page of the application packet.
Thank you!



DENTAL REFERRAL FORM

APPLICANT: You must provide both of these pages (pgs. 9-10) to your General Dentist and return both pages to SCL upon completion.

Check here to confirm that you have included BOTH pages of the Dental Referral Form in your application packet and that your dentist has completed the REQUIRED sections.

Dear Dental Care Provider:

Your patient is applying to the Smiles Change Lives (SCL) program with the hopes of receiving braces at a significantly discounted cost. As this child's dental care provider, you play a significant role in the application process by filling out the Dental Referral Form (DRF) included below. The DRF helps us determine whether or not a patient is a good candidate for our program.

Simply fill out the DRF as completely as possible and your patient will include it as a part of their application packet.

- The "General" and "Dental Health" sections **are REQUIRED**; please fill out these sections completely. If these sections are not filled out completely, your patient's application will not be considered.
- The "Functional" section of the DRF is not required, but is extremely helpful; please fill this section out if you are comfortable doing so.
- Please staple a business card to the DRF so that we can verify that it was filled out by you or a designated staff member.

Thank you very much for taking the time to fill out this child's DRF, and playing a role in their starting on the road to a renewed confidence and brilliant smile.

Sincerely,

The Staff at Smiles Change Lives

DENTIST INFORMATION: *This section is REQUIRED. Application will not be considered if this section is not fully completed.*

Date of most recent visit (*must be within 6 months of application*): _____

Patient Name _____
(First) (MI) (Last)

Dentist Name: _____
(First) (Last)

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

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

Dentist Email: _____

(Continued on next page)



DENTAL REFERRAL FORM
(Must be completed by your general dentist or dental hygienist)

DENTAL HEALTH & GENERAL INFO:

This section is REQUIRED. Application will NOT be considered if this section is not fully completed.

CARIES: Does this patient need restorative work at this time? Yes No

(If "yes", child MUST have restorative work completed before submitting this application. The application will NOT be considered if the child has caries.)

Does this child have good oral hygiene?
 Yes No (Yes or No response ONLY)

How many deciduous (baby) teeth are present?

Impacted teeth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Physically capable of cleaning teeth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Missing Teeth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have second molars erupted? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Other Functional or Aesthetic Problems/Comments: _____

How long has this child been your patient: Less than 1 year 1-3 years 3+ years

Does this patient/family have a positive attitude toward dental care: Yes No

Does this family/patient keep appointments:
 Always Most of the time Sometimes Rarely

FUNCTIONAL: *This section is optional, but extremely helpful.*

Malocclusion:	<input type="checkbox"/> Class I	<input type="checkbox"/> Class II	<input type="checkbox"/> Class III	
Crowding:	<input type="checkbox"/> Mild \leq 3mm	<input type="checkbox"/> Moderate 4-6mm	<input type="checkbox"/> Severe \geq 7mm	
Spacing:	<input type="checkbox"/> Mild \leq 3mm	<input type="checkbox"/> Moderate 4-6mm	<input type="checkbox"/> Severe \geq 7mm	
Overjet:	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate 2-5mm	<input type="checkbox"/> Severe \geq 5mm	<input type="checkbox"/> Underjet
Overbite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate (50-75%)	<input type="checkbox"/> Severe > 75%	<input type="checkbox"/> Open bite
Crossbite:	<input type="checkbox"/> None	<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior	
Misalignment:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Referring Dentist *Signature* (REQUIRED)
 (Please attach a business card for verification)

Date Signed

YOU MUST INCLUDE THIS COMPLETED FORM WITH YOUR APPLICATION PACKAGE