



### 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"/>	Plan to “pay it forward”
<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. Rinchuse has formed a local chapter to serve children in Pittsburgh, PA. 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 Westmoreland, Washington, Allegheny or Armstrong counties of PA.
- 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 – 18.
- 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 ORTHODONTIQUE CHAPTER 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: \_\_\_\_\_

**APPLICANT INFORMATION**

Applicant's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Applicant's Date Of Birth (MM/DD/YYYY): \_\_\_\_\_ Applicant's Age: \_\_\_\_\_ Applicant's Gender:  MALE  FEMALE

Are you currently enrolled in school: YES  NO  What grade are you in : \_\_\_\_\_ What is your GPA: \_\_\_\_\_

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.): \_\_\_\_\_

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 listed organizations? Please 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:**

<input type="checkbox"/> Discomfort while eating/drinking	<input type="checkbox"/> Jaw and/or mouth pain	<input type="checkbox"/> I look down when talking
<input type="checkbox"/> Speech Impediment	<input type="checkbox"/> I get teased about my teeth	<input type="checkbox"/> I cover my mouth when I laugh
<input type="checkbox"/> It's hard to clean my teeth well	<input type="checkbox"/> I'm embarrassed to smile	<input type="checkbox"/> 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)?

What is the best way to reach you: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*\* It is important to understand that orthodontic treatment can span over several years. Can you make your child's treatment a priority?\*\*\***

What is your primary means of getting to their appointments on time? Also, what is your back up plan for transportation (Bus, Friends or Family, Taxi)?

Are there plans of relocating the family in the next two years? If so, where?

What is most important to you about your son/daughter receiving this scholarship?

**Attention Non-Parental Guardians:**

**In order to be considered, you MUST attach copy of medical authorization. If the applicant is in state custody, submit a copy of medical card and consent form.**





## CONTRACT

If selected from the pool of applicants by the board members and screening committee of Smile for a Lifetime Foundation of ORTHODONTIQUE to receive orthodontics, 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 Orthodontique Chapter of Smile for a Lifetime will be provided by Dr. Rinchuse and the team in her 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.Rinchuse and her 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.Rinchuse.
- 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 ORTHODONTIQUE 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. Rinchuse 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	First	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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**Functional:**

Malocclusion:	Class I	Class II	Class III
Crowding:	Mild	Moderate	Severe
Spacing:	Mild	Moderate	Severe
Overjet	Normal	Moderate	Severe
Underjet	Normal	Moderate	Severe
Overbite	Normal	Moderate	Severe
Underbite:	Normal	Moderate	Severe
Crossbite	None	Anterior	Posterior
Misalignment:	None	Mild	Moderate
			Severe

Dentist's Signature \_\_\_\_\_

Date \_\_\_\_\_

## MY PLAN TO “PAY IT FORWARD”

In our community, and all over the world, there is a great need for a great many of things. Being able to help those in need raises awareness and hope in the community and gives us, as individuals, the opportunity to reflect on our own needs versus those of others. We would like to hear from you! Take some time to reflect on the needs of your community. This will take some time and research on your part. Read your local newspaper, talk to a teacher or friend and choose a non-profit /charitable organization you feel you can impact the most in your community or the world.

Think of it as a business plan for your soul!

**Note:** It is important to find something that touches your heart and you are passionate about. For instance, if you love animals, help at a local animal shelter. If you relate to being hungry or even homeless, find a shelter or food bank you can support. The most important thing is that you connect to your community and know that you are making a difference.

### Here are some ideas for you to get started:

#### Collect and donate goods:

Check with a local charity, church, shelter, humane society or orphanage if they need anything.

- 1) Non-perishable food, hygiene items, clothing or toys they are in need of.
- 2) Check around your house and see if there are things that are gently used/loved but no longer needed.
- 3) Check with neighbors, let them know what you are doing and ask if they can help.
- 4) Collect treats, magazines, and hygiene items for soldiers deployed overseas or something to remind them of home.

#### Donate your time:

Check with a local charity, church, shelter, humane society or orphanage if they need volunteers. Every little bit helps.

- 1) Sweeping, Mopping or reorganizing can help considerably when it comes to redistributing goods.
- 2) Support local military personnel through USO or other local non-profits.

### Additional Great Resources

The Watertown Urban Mission

The Salvation Army

### Make note of the information you find, it will help you complete your Plan to pay it forward!

Name of Organization:	Who you spoke with:
Address:	Phone Number:
What they do, what are their goals:	
What they need help with:	
Commitment (How many hours a month and for how long):	
Age requirements, if any:	
Do they have an orientation, If so, When:	
Additional Information:	



### MY PLAN TO “PAY IT FORWARD”

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

**Where:** Where is the organization located? Is there more than one office? Do they have different departments? Which department will you be working in? are there other departments you would be interested in volunteering in? Etc.

**How:** How will you get to your organization? Do you have a backup plan? Are there ways you will prevent being late or missing the commitment you made to the organization? Etc.

**Why:** What is most important to you about helping this organization? Do you have a story that relates to why you want to help them? Etc.

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



**EXAMPLE**

**Who:**

I spoke with Jane Doe at “Lost Dogs” which is a local animal shelter in Boise, Idaho. Jane is the manager at lost dogs. There are a lot of things she needs help with at the facility. Their mission statement says “A kindhearted society is where animals are respected, cared for and valued.” I think it’s very accurate because all animals should be loved. They currently house 52 cats and 27 dogs. They want to help at least 10 animals find a home by the end of the month and to match at least 100 animals with adoption families a year. In the next three years they would like to open another Lost Dogs animal shelter in Lewiston, Idaho.

**What:**

When I spoke with Jane Doe at Lost Dogs, she said that she needs help with things like changing food and water dishes. I will also be able to pet the animals and take them for walks or to the play area outside. They have several kids my age who are also volunteers. Their next orientation is on January 1<sup>st</sup>, 2014 at 1:00pm. That is when I will learn more about Lost Dogs and have a better idea of what I will be doing at the shelter. Once I am trained, I will be able to help wash and shampoo the dogs. I hope that next year, when I am old enough, I will be able to volunteer as a Kennel Assistant.

**Where:**

The Lost Dogs shelter is located at 1234 Main street, Boise, Idaho 10445. There are several departments within Lost Dogs that take care of many different needs of the animals that live there. The media department, for example, they help raise money for the shelter so they can buy food and supplies. There is also an education and community department which helps put the word out about the importance of spaying and neutering your animals. I will be working in the caring for animals department and as a small animal room assistant.

**When:**

Lost Dogs animal shelter asks that we commit to at least eight hours of volunteering a month, for at least six months. This is because it takes time to train the volunteers and they need people they can count on. I have committed to serve a minimum of four hours every weekend. I will arrive at Lost Dogs at 10:00 am and leaving at 2:00 pm. I will do this for at least ten months. If time allows, I would like to volunteer more hours during the summer. Mrs. Doe says that more animals show up during summer months, so there is more that needs to be done. There is also more that needs to be done because most of the fundraising and community events happen in July, August and September.

**How:**

My aunt works at Lost Dogs. She will take me to the shelter on the weekends so I can volunteer. My mom and dad have also agreed to help take me on the weekends when my aunt cannot. I have money kept in my room to take the bus just in case my aunt or parents cannot take me. Maybe, I will meet new friends and we can arrange a carpool to help my parents out with the cost and time of travel. I will do everything I can to fulfill my commitment because I understand what it means to pay it forward and that Lost Dogs is counting on me and so are the animals.

**Why:**

I love animals! I think they are amazing. I am really looking forward to volunteering at lost dogs. Last year, we had lost our cat Fluffy. We looked everywhere for him, we even posted flyers and asked neighbors if they had seen him. It was really sad because I have had fluffy since I was two and I was worried he wouldn’t come home. Thankfully, Mom called Lost Dogs about a week later to find that someone had brought fluffy to the shelter. It was the wonderful people at Lost Dogs who had taken such good care of him. I want to be a part of caring for animals while their families are trying to find them and bring them home. I know how much it meant to me etc.....