Hershey & Heymann Orthodontics

Smile for a Lifetime – Chapel Hill Chapter

1525 East Franklin Street, Chapel Hill, NC, 27514 – 919-967-0474

Smile for a Lifetime – The Gift of Smiles

APPLICATION CHECKLIST

☐	Application – completed, as directed in black ink	☐	Dental Referral Form
☐	Contract – Read and signed by both parent(s) and applicant	☐	Report Card From School
☐	Applicant Questionnaire – handwritten by the applicant	☐	
☐	Household Information – complete and accurate	☐	
☐	2 Letters Of Recommendation – Letters from at least two community leaders or teachers, with contact information attached		
☐	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. Hershey and Heymann Orthodontics has formed a local chapter to serve children in the Chapel Hill, NC area.

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 27516, 27517, 27514, 27312, 27253 or 27243.
- Family income of no more than (185%) of the federal poverty level. (Income eligibility form attached)*

  If Chosen, proof of income will be **required** to verify eligibility prior to treatment. W-2, Income tax return, SSI award letter, TANF grant letter etc.
- Applicant must be between the ages of 11 - 17
- Have "good" dental hygiene practices and had a dental hygiene check-up in the past 6 months.
- Must have a functional and/or aesthetic need for braces.
- Must currently be enrolled in school.
- Must demonstrate a positive attitude.
- Must follow and abide by treatment plan set forth by the orthodontist and contract attached.
- Should demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service.
- Must have positive letters of recommendation from at least two community leaders and/or teachers.

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

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

APPROVAL PROCESS

- The screening committee for Hershey and Heymann Orthodontics will select applicants on a semi-annual 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.

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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.:
				( )	( )

TO BE COMPLETED BY THE APPLICANT ONLY

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 the Boys & Girls Club of America?	YES	NO	Do you have a CASA representative?	YES	NO

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

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

GUARDIAN INFORMATION

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

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

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.

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APPLICANT QUESTIONNAIRE

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

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

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

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

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

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INCOME ELIGIBILTY GUIDELINES

Household Size	Federal Poverty Level	S4L Maximum Annual Income (185% of Poverty Level)	Weekly Gross Income	Monthly Gross Income	Twice Per Month Gross	Every Two Weeks Gross
1	$11,170	$20,665	$398	$1,723	$862	$795
2	$15,130	$27,991	$539	$2,333	$1,167	$1,077
3	$19,090	$36,317	$680	$2,944	$1,472	$1,359
4	$23,050	$42,643	$821	$3,554	$1,777	$1,641
5	$27,010	$49,969	$961	$4,165	$2,083	$1,922
6	$31,930	$57,295	$1,102	$4,775	$2,388	$2,204
7	$34,930	$64,621	$1,243	$5,386	$2,693	$2,486
8	$ 38,890	$71,947	$1,384	$5,996	$2,996	$2,768

Updates to federal poverty guidelines can be found at http://www.fns.usda.gov/cnd/governance/notices/iegs/iegs.htm

HOUSEHOLD INFORMATION

How many people are in your household?	TOTAL:		Number of Adults:		Number of children:	
Is anyone in the household employed?	Yes	No	**If yes, list below**			

PRIMARY SOURCES OF INCOME

Name:		**Name:**	
Employer Name:		Employer Name:	
Hourly wage/Salary:		Hourly wage/Salary:	
Hours worked per week:		Hours worked per week:	
Gross Income per month:		Gross Income per month:	

OTHER SOURCES OF INCOME

Is anyone receiving or going to receive the following:

Lump Sum Payment (Lawsuit/insurance, settlement, social security, SSI, SSDI, Inheritance, lottery, other)?	Yes	No	Amount:		Frequency:	
Child Support or Alimony (please circle)	Yes	No	Amount:		Frequency:	
Unemployment	Yes	No	Amount:		Frequency:	

ARE YOU CURRENTLY RECEIVING ANY OF THE FOLLOWING BENEFITS?

Type of Benefit	Receiving		Amount	Type of Benefit	Receiving	
Food Stamps	Yes	No		School Lunch Program	Yes	No
WIC	Yes	No		State Provided Childcare	Yes	No
TANF	Yes	No		State Provided Healthcare/Dental	Yes	No

EXPENSES

Please do not include living expenses, i.e. car insurance, utilities, groceries etc…

Do you pay for Adult daycare, child support, alimony, child daycare or medical expenses?	Yes	No	**If yes, list below.**

TYPE OF EXPENSE	WHO IS IT FOR	FREQUENCY (Weekly, Monthly, Annually, Semi-Annually)	AMOUNT If selected, you may be asked to submit proof
RENT / MORGAGE			

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CONTRACT

If selected from the pool of applicants by the board members and screening committee of Smile for a Lifetime Foundation of Chapel Hill to receive orthodontic treatment there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance, 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 Smile for a Lifetime Foundation of Chapel Hill will be provided by Dr. Barbara Hershey, Dr. Gavin Heymann and the team at Hershey and Heymann Orthodontics.

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

1) I agree that appointments will be at the discretion of Hershey and Heymann Orthodontics
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. Hershey and Dr. Heymann.
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 Hershey and Heymann Orthodontics or 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. Hershey, Dr. Heymann or Smile for a Lifetime. Rude behavior or an inappreciative attitude is unacceptable.
8) **ATTENTION:** Failure to comply to 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

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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 and Hershey and Heymann Orthodontics. 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		
Dentist's Name:				
	Last	First	Middle	
Dentist's Address:				
	Street	City	State	Zip Code
Dentist's Contact info:				
	Office Phone Number	Alternate Number	Email address	

General Information:

Does the patient need restorative work at this time? Please circle one.	Yes	No
Does the patient have good oral hygiene?	Yes	No
Impacted Teeth:	Yes	No

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

Functional:

Malocculusion:	Mild	Moderate		Severe
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