



Billings Montana Chapter 2370 Ave C. Suite 1

### **APPLICATION CHECKLIST- Submit together in ONE packet**

#### Application

Contract – Read and signed by both parent(s) and applicant

Applicant Questionnaire – handwritten by the applicant

Household Information – complete and accurate

2 Letters Of Recommendation – Letters from (2) two community leaders or teachers, with contact information

4 Photos : 1- Smiling (teeth showing), 1- Profile (lips closed), 1- upper teeth only, 1- lower teeth only

Copy of report card- most recent grading period

Copy of 2013 W-2 for all employed parent(s)/ guardian(s)

**EMAIL: S4L@ olsenortho.com or**

**MAIL TO: Olsen Orthodontics- Smile for Lifetime 2370 Ave. C Suite 1 Billings, MT 59102**

### **ORTHODONTIC SCHOLARSHIP**

Smile for a Lifetime is an international program that provides orthodontic scholarships (free braces) to children ages 11-16 who normally would not be able to afford treatment. Olsen Orthodontics has formed a local chapter to serve 6 children in the Billings, Montana and surrounding area per year. There is no cost to those who receive an S4L orthodontic scholarship. Scholars will be asked to commit to community service hours during the course of their treatment (1 hour of service per estimated month of treatment (if treatment time is estimated at 24 months, then 24 hours of volunteer service will be required by the scholar). Scholars are chosen by a local board of directors and the process is competitive. **Scholarships are limited** and based on financial need, orthodontic need, applicant character, and a complete and accurate application. Olsen Orthodontics may require a brief screening to evaluate the overall orthodontic need.

#### **QUALIFICATIONS**

- Applicant must reside in Montana.
- Family income of no more than 185% of the federal poverty level. Income eligibility form attached
- Applicant must be between the ages of 11-16 \* and must demonstrate a positive attitude.
- Have good dental hygiene practices.
- Must have a functional and/or aesthetic need for braces.
- Must currently be enrolled in school with at least a **2.7 GPA**
- Must follow and abide by treatment plan set forth by the orthodontist and contract attached.
- Should demonstrate involvement in the community through extracurricular activities and/or volunteer service.
- Must have positive letters of recommendation from (2) two community leaders and/or teachers.
- Must be able to give community service/volunteer hours while in treatment.

\* Chapter may consider special circumstances. Please email our representative for more information- [S4L@olsenortho.com](mailto:S4L@olsenortho.com)

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

#### **APPROVAL PROCESS**

- Olsen Orthodontics will select 2 applicants every four months (semester). Applications are accepted year-round, but you will only be considered for the semester in which it was received. **1<sup>st</sup> Semester:** January 1-April 30; **2<sup>nd</sup> Semester:** May 1-August 31; **3<sup>rd</sup> Semester:** September 1-December 31.
- Selection is based on the information provided within this packet, along with your orthodontic and financial need.
- Please ensure that the packet is filled out completely and accurately. Incomplete packets will not be submitted to the review board for selection process.
- If you are not selected, you will need to resubmit your entire application. Applicants may reapply 3 times.



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## ORTHODONTIC SCHOLARSHIP APPLICATION FORM

Today's Date:

### APPLICANT INFORMATION

Last :  First:

Address (City, State, Zip Code):

DOB:  Email:  Cell:  Home:

Guardian's Name:  Guardian Cell:

Guardian's Email:  Guardian Home:

Applicant's Gender:  Grade in school:  Name of School:

Have you had braces before?  GPA:

If you are 16 years old, what are your plans over the next 3 years (Moving, College, etc.)?

Dentist & Date of last exam and cleaning:

What organization do you plan on working with to satisfy your needed volunteer hours?

How did you hear about Smile for a Lifetime (please circle or write in your answer):

Internet Search	Church	Friend/ Family	Dentist/Orthodontist	Boys & Girls Club	State Office	Other: (Please Specify)
Television	Your School	Radio	Newspaper	CASA	Internet Ad	

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

Jaw and/or mouth pain	I cover my mouth when I laugh	I have been told that I snore when I sleep
Difficulty eating certain foods	I look down when talking	I am missing adult teeth
Speech Impediment	I get teased about my teeth	
It's hard to clean my teeth well	I'm embarrassed to smile	

### PARENT/GUARDIAN INFORMATION

Father/Guardian's Occupation:  Employer:  Employer phone #:

Mother/Guardian's Occupation:  Employer:  Employer phone #:

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:

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

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?



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## APPLICANT QUESTIONNAIRE

**HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format.**

Tell us about yourself- what are you excellent at doing, your extracurricular activities, and the types of goals and aspirations in life. Etc.

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



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INCOME ELIGIBILITY GUIDELINES						
Household Size	Federal Poverty Level	\$4L 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 FINANCIAL INFORMATION

How many people are in your household: \_\_\_\_\_ Number of Adults: \_\_\_\_\_ Number of children: \_\_\_\_\_

Is anyone in the household employed? Yes N **If yes, list below**

### PRIMARY SOURCES OF INCOME

Father/ Guardian:	Mother/Guardian 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)?	Y	N	Amount:	Frequency:
Child Support or Alimony (please circle)	Y	N	Amount:	Frequency:
Unemployment/ Disability	Y	N	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

**Include a copy of last year's W-2 for each parent/guardian.**



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## CONTRACT

If selected from the pool of applicants, by the board members of Smile for a Lifetime Foundation and by Olsen Orthodontics, 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 the Billings, Montana Chapter of Smile for a Lifetime Foundation will be provided by a certified orthodontist.

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

- 1) I agree that appointments will be at the discretion of Olsen Orthodontics.
- 2) I understand that this can mean scheduling appointments during non-peak hours and during school.
- 3) I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result, and is a requirement of accepting treatment.
- 4) I also understand that compliance with Doctor's instructions is essential to treatment success and is a requirement of accepting care.
- 5) If you must reschedule appointments, give Olsen Orthodontics at least 24 hours' notice. If more than two appointments are missed or appointments are continually 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.
- 7) One set of retainers will be provided as a part of the scholarship award, any replacements will not be covered by Olsen Orthodontics or Smile for a Lifetime.

**Direct responsibilities of the patient:**

- Maintain excellent oral hygiene (tooth brushing, flossing).
- Follow the rules for eating- this will minimize breakage of appliances and is necessary for satisfactory completion of treatment.
- Cooperate. More than two (2) loose or broken brackets may result in discontinuation of treatment.
- Patient must follow all of the orthodontist's and clinical assistant's instructions. For example, elastic wear instructions.
- Attitude. You will be expected to maintain a respectful attitude once accepted into orthodontic treatment.

Failure to comply with patient and parent/guardian responsibilities may result in removal of orthodontic equipment and discontinuation of treatment. Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program.

**Media Disclaimer:**

If your child is chosen, you consent to Olsen Orthodontic's and Smile for a Lifetime's (S4L) use, without charge, of all photos, video and audio recordings of your child for :

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 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 Olsen Orthodontics and S4L for fundraising or other promotional and advertising purposes.

**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. **Non-parental guardian:** 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.

Father/Mother/Guardian Signature

Printed Name

Date

**I certify that all information I have provided is true and correct:**

Applicant Signature

Printed Name

Date



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Dear Dental Care Provider,

Your patient is applying for an orthodontic scholarship through the Billings Montana Chapter of Smile for a Lifetime. **If selected**, the patient will receive free orthodontic care through Olsen Orthodontics and S4L 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	Middle
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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?

Does the patient have good oral hygiene? Yes No

Does the patient have any primary teeth:  
If so, which ones?

Impacted Teeth: Yes No

If so, which ones:

Missing Teeth:

Have second molars erupted: 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: Always Mostly Sometimes Rarely Never

### Evaluation

Occlusion Class:	Class I	Class II	Class III
Crowding:	Mild	Moderate	Severe
Spacing:	Mild	Moderate	Severe
Overjet	Normal	Moderate	Severe
Overbite	Normal	Moderate	Severe
Crossbite	None	Anterior	Posterior

Dentist's Signature

Date

Thank you very much for taking time to assist your patient in completing their scholarship application!