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610.374.4097 | pfs@fantasticsmiles.com

ROG Orthodontic Scholarship Program Application

Our goal is to provide area youth with significant need for braces and financial struggles the opportunity to receive orthodontic care free of charge. In return, our recipients are required to volunteer a minimum of 40 hours within their community throughout their orthodontic treatment. A volunteer log, which will be given to the patient upon acceptance, must be filled out and brought to each appointment.

How to apply:

1. Call ROG Orthodontics to schedule a complimentary consultation to meet with one of our doctors prior to submitting an application.
2. Read and agree to the Participation Guidelines and Requirements.
3. Complete and submit the following application **along with all required documents**. You may either mail, hand-deliver, or email your completed application.

Participation Guidelines:

- Must be between the ages of 11 and 18
- Must have a significant aesthetic or dental need for braces
- Must be a resident of the local ROG Orthodontics service area
- Must have a family income of no more than 185% of poverty level
  http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html
  (if applicant qualifies for free or reduced price school lunch, they would meet the financial qualifications)
- Must follow the treatment plan and demonstrate the ability and commitment to make all appointments on time
- Must agree to see their dentist every six months
- Must complete 40 hours of community service over the course of treatment
- Must be of good character.
- Must have a positive attitude!

Application Requirements:

- Two letters of recommendation. These letters can be from a teacher, community leader, guidance counselor, dentist, etc. Letters should not be from family members.
- Must complete answers for all the questions on the application.
- Must provide a copy of the applicant's last report card or school transcript.
- Must provide proof of income.
- Application essays must be completed by the applicant only. Essays completed by someone other than the applicant will be disqualified.
- Applications that are incomplete or do not meet the criteria above will not be sent to our Board of Directors.

All applicants must meet with one of our doctors prior to submitting an application. If you have not been seen for a complimentary consultation at one of our three offices, please call ROG to schedule an appointment at your earliest convenience.

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Application for ROG's Orthodontic Scholarship Program

Applicant's name: _____

Submitted by (circle one): Self Parent Pastor School Counselor Dentist Other: _____

Applicant's address: _____

Applicant's date of birth: _____ Age: _____ Gender: _____

School: _____ Grade in school: _____ GPA: _____

Parent/Guardian's Name: _____

Parent/Guardian's phone number (s): _____ E-mail Address:_____

The applicant is an excellent candidate for Project Fantastic Smiles because: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did you hear about Project Fantastic Smile? _____

Does the applicant see a dentist regularly? _____ Applicant's dentist: _____

Dentist's Phone number: _____

Does the applicant qualify for Medicaid? _____ Is the applicant eligible for free or reduced price lunch? _____

Is the applicant covered by dental insurance? _____ Name of insurance company: _____

If selected, would the applicant be able to volunteer for 40 hours in the community? _____

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INCOME ELIGIBILITY GUIDELINES

Household Size	Federal Poverty Level	PFS 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	$1723	$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	$2,082	$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 https://aspe.hhs.gov/poverty-guidelines

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/MORTGAGE			

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APPLICANT QUESTIONNAIRE

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

Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? What are your goals and aspirations?

Tell us about your family. How many siblings do you have? Who are they? What do you like to do together?

Why do you want braces? How do you feel about your smile now? How do you think braces will improve your life now and in the future?

If you had a chance to do a favor for another young person (or people) without any expectation of being paid back, what would you do?

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DENTAL REFERRAL FORM

Dear Dental Care Provider,
Your patient is applying for an orthodontic scholarship program. If selected, the patient will receive free braces through the Project Fantastic Smiles. As the child's dental care provider, it is very important we receive your feedback 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's Name:				
	Last	First	Middle	
Dentist's Name:				
	Last	First	Middle	
Dentist's Address:				
	Street	City	State	Zip Code
Dentist's Contact Info:				
	Office Phone Number	Alternate Number	e-mail 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	Does the patient have baby teeth?			Yes	No	If so, how many?					
Impacted teeth?	Yes	No	If so, how many?		Missing Teeth:	Yes	No	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? (please circle one)	Always	Mostly	Sometimes	Rarely	Never

Functional

Malocclusion:	Class I	Class II	Class II	
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:	Normal	Moderate	Severe	
Misalignment	None	Mild	Moderate	Severe

Notes:

Dentist's Signature	Dentist's Full Name	Date

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CONTRACT

If selected from the pool of applicants by the board members of Project Fantastic Smile to receive orthodontic treatment, there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance provided by ROG Orthodontics, if requested, but all applicants are chosen by a vote of the board. It 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 will be provided by certified orthodontists; Dr. Robert Doleva, Dr. Natalie Parisi, Dr. Adina Wolfe, and Dr. Dennis Mauro of ROG 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 ROG Orthodontics.
2. I understand that this means I may be scheduling appointments during non-peak hours i.e. mornings Monday through Friday.
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 it is a requirement of accepting care from ROG Orthodontics.
5. If you must reschedule appointments, please give ROG Orthodontics at least 24 hours' notice. If more than two appointments are rescheduled, you 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, you may incur a charge to continue your treatment elsewhere.
7. One retainer will be provided as a part of the scholarship award. Any replacement will not be covered by ROG Orthodontics.

DIRECT RESPONSIBILITIES OF THE PATIENT:

- Maintain excellent oral hygiene (tooth brushing, flossing). If unwilling to meet expectations due to medical and dental health risks, treatment will be discontinued.
- 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.
- Cooperation: Excessive breakage – more than two (2) loose brackets may be deemed sufficient evidence that cooperation is not sufficient to meet minimal requirements for treatment; failure to comply with instructions to maintain auxiliaries including elastics and springs.
- 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 ROG Orthodontics. Rude behavior or an inappreciative attitude is unacceptable.

ATTENTION: Failure to comply to your responsibilities may result in removal of orthodontic appliances and discontinuation of treatment

Applicant's Initials: _____

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: _____

Media Disclaimer: If your child is the chosen applicant, you consent to ROG's use, without charge, of all photos, video, and audio recordings of your child. ROG may 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.

Legal Guardian Consent: I certify that I am the legal guardian of the child on this application. I have all rights and authority to make medical decisions for the child, and 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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Please use this chart to ensure you are submitting a completed application. Incomplete applications will be returned.

	Application for Orthodontic Scholarship
	Completed essays
	Income Eligibility Sheet
	Proof of Income (one month of pay stubs, W2s, or 1040s)
	Signed contract sheet
	Dental form (to be filled out by your dentist)
	Most recent report card
	First letter of recommendation
	Second letter of recommendation

To:

ROG Orthodontics
1268 Penn Avenue
Wyomissing, PA 19610

{or hand-deliver to one of our offices}

Or email to: PFS@fantasticsmiles.com

No documents will be returned and all will become the property of ROG Orthodontics and Project Fantastic Smile.

Please note that this is a competitive scholarship program. Candidates are evaluated on the basis of clinical and financial need, as well as character, commitment to treatment, and attitude. It is in the applicant's best interest to provide as much information as possible so the Board of Directors can best assess the applicant's situation and character.

Our Board of Directors will review completed applications. Again, all applicants must meet with one of our ROG doctors prior to submitting an application. If you have not been seen for a complimentary consultation at one of our three offices, please call to schedule an appointment at your earliest convenience.

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