Guidelines in applying for braces through the Smile for a Lifetime Foundation:

- **Two letters of recommendation** are mandatory. Please do not submit more than two letters, and limit each recommendation letter to one page each. Please type or print clearly with black ink (no pencil). Letters of recommendation must be *written by professionals – teachers, coaches, dentists, counselors, pastors, etc*

- A clear **5x7 head-shot photo with full smile & teeth showing must be included** with application

- The General Dentist Form must be completed by the applicant's general dentist and/or hygienist and submitted with the application

- The application, letters of reference and photos will **not** be returned and will become property of Smile for a Lifetime Foundation

- Applicant must be a resident of the Northwest Arkansas area

- Applicant must have a positive attitude

- Applicant must agree to follow the treatment plan and demonstrate the ability and commitment to keep and make all appointments on time

- Applications will be reviewed on a quarterly basis. Our quarters are:
  Jan 1-March 31, April 1-June 30, July 1-Sept 30, and Oct 1-Dec 31

- Each applicant will be notified of approval or denial after the end of each quarter

Return the completed application, General dentist form, letters of recommendation and photo together in **one packet** to:

Smile for a Lifetime Foundation
PO Box 858
Bentonville, AR 72712

Questions:
s4l.nwa@gmail.com

**Applications that do not meet these criteria will be considered incomplete and will NOT be voted on by our Board of Directors.
***Let it be noted that while the orthodontists have agreed to be orthodontic providers for this foundation, they do not serve on the Board of Directors. (they do not personally choose the recipient of the orthodontic scholarship).

- **A completed General Dentist Form**
- **A 5x7 head shot photo of applicant with full smile and teeth showing.**
- **Two letters of recommendation – typed and limited to one page each. Letters of recommendation must be written by professionals – teachers, coaches, dentists, counselors, pastors, etc.**
- **Applicant Questionnaire**

*Application must be complete and not missing any information to be considered
**All applications, pictures and supporting documents will NOT be returned and become property of Smile for a Lifetime foundation

Applicant Information:

Name: ______________________________ Birthdate:___/___/____ Age:________ Sex:__________ Grade:________

Have you applied for Smile for a Lifetime before? **Yes** **No** If so, how many times have you applied? ________

Has the applicant ever been evaluated or treated by an orthodontist? **Yes** **No**

If yes, Orthodontist Name: ____

Does the applicant qualify for treatment through Medicaid or AR Kids? **Yes** **No**

Is the applicant covered by dental insurance? (Specify company and id#) ______________________________________

Parent(s)/Guardian Information:

Name: ____

Address: _______________________________________ City: ___________________ State: _____ Zip: __________

E-mail Address: ____

Phone Numbers: Home: ________________________ Cell:__________________________

Annual household income: _______________ # of household members: ______________

Employer(s): 1) ___________________________ 2) ______________________________

Submitted by (circle one): Self Parent School Counselor Dentist Other____________

How did you hear about Smile for a Lifetime? ____

Please explain why this applicant is deserving of orthodontic care through the Smile for a Lifetime program. If applicant is applying on behalf of his/herself, please describe what it would mean to you if you received orthodontic treatment through Smile for a Lifetime. (May attach one additional page if needed)

Please tell us about your current financial situation and why it is not possible for your family to afford orthodontic treatment at this time.

Applicant Questionnaire:

Tell us about yourself. What are your interests and hobbies? What extracurricular activities are you involved with? Do you participate in any community service or volunteer projects?

What are you goals for your future?

Why do you want braces?

How do you feel about your smile now?

How do you think braces could improve your life now and in the future?

If you are chosen to receive free treatment, please list 3 ways you will help others in our communities over the next 18 months.

1.)

2.)

3.)

GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

Date: __________________

Applicant's Name: ____

Applicant's Birthdate: __________________

General Dentist:____

Office Phone: (______)______-_________

# of remaining primary teeth: _______

Dental conditions that could be improved with orthodontic treatment: ____

____

Date of last dental cleaning & exam: __________________

Please check one:

____ Patient has received a cleaning and is cavity free.

____ Patient has received a cleaning and completed all restorative treatment.

____No additional treatments are necessary.

____ Patient has received a cleaning & restorative treatment has been scheduled.

List restorative treatment needed & scheduled dates treatment is to be completed:

____

____

____

Signature of Dentist/Hygienist

____

Printed name of Dentist/Hygienist