# Med Center Health Foundation-Malchow Endowment Patient Application

## DIRECTIONS FOR APPLYING TO BRIGHT SMILES, BRIGHTER FUTURES PROGRAM

We are so pleased to be able to consider your child for the Malchow Bright Smiles, Brighter Futures Program. Listed below are tips that will make sure your application has the best opportunity for consideration.

1. Complete all sections and information requested on the application form.

2. Include Proof of Income with your most recent 1040 filing or a series of at least 3 paystubs for each working spouse/guardian.

3. Include your child's general dentist's letter stating why your child would benefit from orthodontic treatment.

Our application review committee is comprised of 6 -7 individuals with experience in the dental field. The committee meets quarterly to review all applications received since the previous selection date. Currently our committee meets in February, May, August and November of each year. There are always more applicants than spots in the program, but if a child is not chosen during their first review cycle, they will automatically be added to the applicants for up to the next three selection rounds. A child's application will remain in the applicant pool for up to 1 year.

After each selection meeting, all applicants will be notified as to the status of their application. Several criterion are considered when reviewing applications such as the child's age, degree of misalignment, primary tooth status, and overall dental health of the child. The selection of the committee is final.

Questions can be directed to mailto:REAGCJ@mchealth.net.

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## ORTHODONTIC APPLICANT INFORMATION

Patient Name _____ DOB_____ AGE _____
Gender : ☐ Male ☐ Female

Address_____
City_____ , Kentucky Zip_____ County _____

Does applicant live with ☐ Both parents ☐Single Parent ☐Other Relative Gender : ☐ Male ☐ Female
☐Foster Parent ☐ Other Guardian relation _____

Name of School Attending _____ What grade level?_____

Name of Applicant's Dentist_____ Office Phone _____

Date of last Dental Cleaning _____ Date of Next Scheduled Cleaning _____

Has applicant's dentist made a recommendation for orthodontics? ☐ Yes ☐ No

**For what conditions are braces required? Please check all that apply.**

| | | |
|---|---|---|
| ☐ Speech impediment | ☐Gross Misalignment | ☐ Gross Overbite |
| ☐ Jaw/TMJ Pain | ☐Early loss of primary teeth | ☐ Gross Underbite |
| ☐ Difficulty Chewing | ☐Crowding | ☐ Excessive Grinding |

☐ Other _____

**Which of the following apply to applicant? Please choose all that apply**

☐ U.S. Citizen ☐ Documented Immigrant ☐ Non-Documented Immigrant ☐ Homeless ☐ Migrant

☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino (All Races)

☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Multi-Racial

☐Other_____

## PARENT/ GUARDIAN INFORMATION

How many parent(s)/Guardian(s) are involved with medical/dental decisions for this applicant? _____

Parental Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

**Primary Guardian(s) / Parent(s) Information:**

Name _____ Phone: _____
Address : _____
City: _____, State_____ Zip _____ Does applicant live in your home?_____
EMAIL ADDRESS: _____

**Additional or Secondary Guardian/Parent Information if not living in the same home.**

Name _____ Phone: _____
Address : _____
City: _____, State_____ Zip _____ Does applicant live in your home?_____
EMAIL ADDRESS: _____

**INCOME ATTESTATION**

By the terms of the Malchow Endowment , applicants will be screened for family income that falls above the Medicaid threshold of 138% and below 200% of the National Poverty Guideline.

Proof of Income provided by: _____Most recent 1040 _____Other: _____

Total Monthly household income **$_____** Total Annual household income $_____

Source of income: ☐ Employment ☐ Social Security ☐ Disability ☐ Pension ☐ State Assistance Program

How many total people are in your family? (includes parent(s) and dependent children) _____

**INSURANCE ATTESTATION**

By terms of the Malchow Endowment Funding Agreement, applicants are uninsured or *under*insured by the terms of their insurance coverage.

**Please check all coverages that currently cover this applicant:**

☐ MEDICAL INSURANCE ☐ PRIVATE DENTAL INSURANCE ☐ MEDICAID/KCHIP ☐ SSI/SOCIAL SECURITY
☐ NO INSURANCE /UNINSURED ☐ UNDERINSURED

**OTHER FINANCIAL CONSIDERATIONS:** With my signature, I understand that should there be other dental services required during the time my child remains in orthodontic braces, including but not limited to: tooth extractions, wisdom teeth removal, fillings, cleanings, etc.; that these expenses are not covered under the orthodontic fund and remain the sole responsibility of the patient. I understand also that there is a $4500 maximum allowance per child and any expenses that exceed this amount will be the sole responsibility of the patient.

_____Guarantor Signature

**In 100 words or less, tell our committee why this application should be considered for funding. What unique circumstances might currently contribute to the unaffordability of braces for this child without the financial assistance of this program? This essay may also be written or typed on a separate piece of paper.**

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## SIGNATURE

**I attest to the truthfulness of the information provided. I authorize the selection committee to contact me, my applicant's dentist, school officials, or reference other verification tools to verify the validity of this information given. I understand that a committee of professionals will select the most appropriate candidates for use of the endowment funds based on severity of oral malformation, financial need, or situation presented on a quarterly basis. I understand that my application will stay on file for consideration for one full year, after which I understand I must reapply for continued consideration.**

_____ _____

Parent or Guardian Signature Date