SHARE A SMILE INITIATIVE
Program Guidelines and Application

At Austin Orthodontic Arts, we are dedicated to transforming the lives of our patients and our community at large through our commitment to skill, service, and results. We see our work as a life-long investment in the future of our patients and of our community. That's why we are committed to giving back to our community through our SHARE A SMILE initiative. AOA is happy to provide this **once in a lifetime opportunity** for your child to receive braces at no cost.

QUALIFICATIONS: Your child must meet ALL qualifications to apply to the program.

· Be 10-18 years of age (must receive application prior to the child's 19th birthday)

· Have no more than four (4) baby teeth; if you need more information on how many baby teeth your child still has, please ask your child's dentist

· Have "good" oral hygiene (as certified by the child's general dentist within 6 months of receipt of application)

· Have no unfilled cavities

· Have a moderate to severe need for braces

· Not be wearing braces currently

· Have a total household income at or below 200% of the Federal Poverty Level (see page 4 for more information)

- Federal Poverty Levels can be determined by visiting https://www.healthcare.gov/glossary/federal-poverty-level-FPL/

APPLICATION PROCESS:

· Upon receipt of a **COMPLETE** application, the application will be reviewed and the family will be notified whether or not the child qualifies for the next step in the application process.

· Once AOA has received a complete application, it will be reviewed by the AOA Review Panel and the family will be notified whether the child (i) is qualified for the program and will placed on a wait list, (ii) is declined for the program, or (iii) will need further evaluation (due to poor oral hygiene, dental development, or other potential issues).

> *· NOTE: The waiting period for this step of the process varies and can be longer than twelve (12) months based on demand.* ***AOA cannot make any guarantees of acceptance into the program****. If a child is 17 or older when he or she applies, please be aware that the chances of acceptance are greatly reduced depending on wait times as treatment cannot be started after a child turns 19.* ***If treatment has not started BEFORE your child turns 19, he or she will be removed from the wait list and will no longer be eligible for treatment.***

APPLICATION CHECKLIST

(must be signed and included with submitted application)

All of the items below must be FULLY completed and submitted to AOA for EACH child that is applying to the program. Use this checklist to indicate that you have included each required document; that each has been fully completed; and that all items are signed where required. **If your application is INCOMPLETE, it will be returned to you and in order to be considered for the program.**

☐ **General Application** (pg 3-4)

☐ **Child's Application** (pg 5)

☐ **Notice of Privacy Practices** (pg. 6 – MUST be signed by parent/guardian)

☐ **Program Rules and Guidelines** (pgs. 7 - All items MUST be **initialed** by parent/guardian)

☐ **Parent/Legal Guardian Consent & Hold Harmless** (pg. 8–MUST be signed by BOTH parent/guardian & child)

☐ **Dental Referral Form** (pgs. 9-10 - Must be FULLY completed by child's dentist or dental hygienist based on an exam **no more than 6 months prior** to the receipt of application and show good oral hygiene, no unfilled cavities & four or fewer baby teeth remaining)

☐ **Photos of the child are required.** Photos should show the child's teeth and smile as clearly as possible. Photos should show the main problems clearly so that we can adequately assess the child's need for orthodontic treatment. All photos must be PRINTED and have the child's full name written on the back of each photo. Color photos preferred.

☐ **Federal Tax Form 1040/1040A/Supplemental Security Income (SSI) Awards Letter**: Proof of income MUST be submitted in the form of either a COMPLETE copy of the most recent year's federal tax return (include ALL pages, schedules or statements) AND/OR a copy of a current SSI awards letter**.** Tax forms/SSI awards letters that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted**. **If you are submitting applications for more than one child, you MUST include a copy of your tax form/SSI awards letter with EACH application. See page 4 for additional information on this requirement.**

☐ **Personal essay from the child and/or letters of support** detailing why the child wants/needs braces, how they feel their life might be improved as a result of treatment, etc. (This is optional but strongly encouraged)

*** Additional documentation required for non-parental guardians:**

☐ Non-parental guardians must submit a copy of their authorization to make medical decisions (e.g., court order).

☐ For children in state custody, copies of the child's state medical card and medical consent must be submitted. Note: a child in state custody is not required to submit proof of income.

_____ _____

Signature of parent/guardian **Date**

Mail COMPLETE application to: **Austin Orthodontic Arts, PLLC 5718 Balcones Dr. Austin, TX 78731**
Please ensure you use adequate postage and keep a copy of your completed application for your records.

GENERAL APPLICATION
(To be completed by parent/guardian; please write clearly)

I. CHILD'S PERSONAL INFORMATION

_____ _____ _____ _____
Child's **Legal** Last Name Child's **Legal** First Name Middle Initial Child's Nickname (if any)

_____ _____ - _____- _____ _____
Child's Date of Birth Social Security Number Gender

_____
Street Address City State Zip

_____ ☐cell ☐home _____
Phone Number Email

_____
Name of School Grade School City, State

II. PARENT/GUARDIAN'S PERSONAL INFORMATION

_____ _____ _____
Custodial Parent/Guardian Last Name First Name Relationship to Child

_____ _____ _____
Home Phone Cell Phone Email **(required)**

_____
Address City State Zip

Marital Status: _____ Spouse/Partner's Name: _____ Relationship to Child: _____
Spouse/Partner Phone: _____ Email: _____
If child doesn't live with both parents, name of non-custodial parent: _____

FOR NON-PARENTAL GUARDIANS, you **MUST** submit a copy of your medical authorization. For children in state custody, submit a copy of their state medical card and consent.

III. OTHER INFORMATION

Have any of the child's family members applied to or been treated at AOA? If yes, please list their name(s): _____

How will the child get to his/her orthodontic appointments? _____
_____
_____

Please list any health issues your child has that we should be aware of: _____
_____
_____

Are you or any member of your immediate family currently wearing Invisalign? □Y □N Braces?□Y□N
Name of family member(s) and relationship to child: _____
Name/Address of treating orthodontist: _____

GENERAL APPLICATION CONT.
(To be completed by parent/guardian; please write clearly)

IV. FINANCIAL: Qualification for our program requires a total household income **at or below** 200% of the Federal Poverty Level for the most recent tax year.

You **MUST** submit a copy of your most recent **Federal Tax Form 1040, 1040A** or **Supplemental Security Income (SSI) award letter as proof of income** (note: we do not accept Social Security benefits letters as proof of income). If you do not file Form 1040 or 1040A or receive Supplement Security Income benefits, your application will NOT be approved. We DO NOT accept any other type of proof of income. Tax forms/SSI awards letters that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted**. **If you are submitting applications for more than one child, you MUST include a copy of your tax form/SSI awards letter with EACH application.**

If submitting Form 1040/1040A, please note:

- Page one of Form 1040/1040A (line 37 on 1040 and line 21 on 1040A) must show adjusted gross income at or below 200% of the Federal Poverty Level.
- The child applying MUST be listed as a dependent on either page one of Form 1040/1040A or on Statement 1 along with the child's Social Security number.
- If the child is NOT claimed as a dependent on your tax return, you must explain why and ALSO submit the tax return for the person who DOES claim the child, as well as proof of where the child resides (e.g. school records). In this situation, BOTH tax returns must be submitted and each must separately meet our income qualifications.
- If the child lives with both parents, and a joint return is not filed, the separate tax returns of BOTH parents must be submitted to show total household income. In this situation, the total adjusted gross income of both parents combined must meet our income qualifications.
- Even if your income level doesn't require you to file taxes, you must do so to apply to our program, even if your income is $0.

V. INSURANCE INFORMATION: This information is **not** a factor in determining eligibility

Is child covered by Medicaid/State Program? ☐ Yes ☐ No

Is child covered by dental insurance? ☐ Yes ☐ No

VI. HOW DID YOU HEAR ABOUT SHARE A SMILE? Please include details where possible.

_____ Web search- what words or phrases did you search? _____
_____ Website- name of site or organization _____
_____ Family/Friend-name _____
_____ SAS Current Participant Referral-name_____
_____ Dentist (your regular dentist)-name/location _____
_____ Dental school/clinic-name/location _____
_____ Orthodontist-name/location_____
_____ Newspaper/magazine-publication name _____ date _____
_____ TV/Radio-station name _____ date _____
_____ Event (example: health fair) please describe _____ date _____
_____ Other-please describe _____

Please be as detailed as possible when filling out the information below as this information helps us determine your need for braces. This will be sent to our AOA Review Panel for consideration for our Share a Smile program.

CHILD'S APPLICATION

(To be completed *by the child*; please write clearly)

Child's Name: _____

Are you currently wearing braces? □ Yes □ No

Below are some of the reasons why people get braces. Select all that apply to you.

I am embarrassed by how my teeth look.	A lot	A little	Not at all
I have difficulty eating and/or drinking.	A lot	A little	Not at all
I have pain in my mouth and/or jaw.	A lot	A little	Not at all
People make fun of my teeth.	A lot	A little	Not at all
I have difficulty talking.	A lot	A little	Not at all
I'm afraid to smile.	A lot	A little	Not at all
I cannot clean my teeth very well.	A lot	A little	Not at all
I cover my mouth when I talk or smile.	A lot	A little	Not at all

If anyone has ever made fun of your mouth or teeth, please give us examples of what people have said:_____

_____

How do you think your life will change when you get braces?

_____

_____

What are your plans for the next 2-3 years? Are you planning to move away from your current area?

_____

_____

Is there anything else you would like to share with us? (hobbies, school activities, music, sports, etc.)

_____

_____

Why is it important for you to get braces? Why do you want/need braces? (Be as detailed as possible and use extra paper if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your protected health information may be used by staff members, volunteers, agents and doctors at Austin Orthodontic Arts, PLLC (AOA) and disclosed to other health care professionals, including but not limited to your assigned screening and treatment provider(s), for the purpose of evaluating your application and providing your treatment.

Program Operations: Patient information, including first name, case history and photographic images may be used as necessary to support assessment, public relations, fund development and other activities of AOA.

Law enforcement: Your protected health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your protected health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your protected health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you noticed us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include: The right to get an electronic or paper copy of your record ▪ The right to request confidential communications ▪ The right to request restrictions on the use and disclosure of your protected health information ▪ The right to inspect and copy your protected health information ▪ The right to amend or submit corrections to your protected health information ▪ The right to receive an accounting of how and to whom your protected health information has been disclosed ▪ The right to receive a printed copy of this notice ▪ The right to file a complaint.

Austin Orthodontic Arts' Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice and to notify you when a breach of your unsecured protected health information has occurred.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting AOA at the address below.

Complaints Contact Person: If you would like to submit a complaint or have questions regarding our privacy practices, you may contact us in writing at the following address: Austin Orthodontic Arts 5718 Balcones Dr. Austin, TX 78731, or you may also contact the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after 07/01/2015.

I, _____ have received a copy of Austin Orthodontic Arts' Privacy Practices.
Custodial Parent or Legal Guardian **PRINTED NAME**

_____ _____
Custodial Parent or Legal Guardian **SIGNATURE** **DATE** (mm/dd/yyyy)

Program Rules and Guidelines

Austin Orthodontic Arts, PLLC (AOA) is happy to provide this **once-in-a-lifetime** opportunity for your child to receive braces – it is an opportunity that many children do not receive. However, we will only provide treatment if you and your child fully cooperate with the treatment provider and his/her treatment plan. All of the following conditions must be met to be eligible to start treatment and to continue treatment.

PARENT/GUARDIAN: PLEASE READ CAREFULLY AND INITIAL EACH ITEM.

_____1. AOA provides for orthodontic treatment ONLY. Extractions, cleanings, oral surgery or other treatment that may be necessary before, during or after orthodontic treatment are the financial responsibility of the participant's parents or legal guardians.

_____2. Your child must have been seen by a dentist within **6 months** of receipt of his/her application. Your child's dentist must complete the Dental Referral Form, indicate good oral hygiene and all necessary treatment must be completed before braces will be applied. If your child has cavities or periodontal disease, these conditions must be completely remedied before treatment is started. Your child must have regular dental cleanings every six months during treatment. During the course of treatment, if your child's teeth are not cleaned properly, cavities can form around the braces. Your child may be removed from the program at any time due to poor oral hygiene.

_____3. Treatment spots are limited and **AOA cannot make guarantees of acceptance even if your child qualifies for the program**. Waiting periods vary and can be longer than twelve (12) months based on demand. During this time, you may be required to submit updated documents, including an updated Dental Referral Form and 1040/SSI letter to ensure your child still qualifies for the program. If treatment has not been started BEFORE your child turns 19, he/she will be removed from the program and will no longer be eligible for treatment.

_____4. Regular appointments are required to make sure teeth move as expected. Since AOA is donating treatment, we may require you to attend appointments during non-peak hours. As a result, your child's appointments will likely be scheduled during the mid-morning or mid-afternoon hours. It is your responsibility to make sure that all scheduled appointments are kept. If you must cancel or reschedule an appointment, you are required to give your doctor at least 24 hours notice. **Not calling to cancel or missing an appointment is grounds to remove your child from the program and have your child's braces removed**.

_____5. You and your child must fully follow the treatment plan set by AOA, which will be explained to you before treatment starts. If you fail to follow the treatment plan, including but not limited to proper use of bands, appliances, and retainers, AOA has the option to refuse to continue treatment and to remove braces.

_____6. If you move before treatment concludes, please inform AOA in writing as soon as you are aware of the move. You will be removed from the program and will be responsible for making arrangements to complete your child's care. You may either have AOA remove the braces or you may locate a new treatment provider in your new community for which you will be financially responsible. AOA is not responsible for locating a new treatment provider or paying for continued treatment.

_____7. **AOA donates their services based upon your child's qualification for the Share a Smile program, both in terms of orthodontic and financial need. As such, it is important that you treat the doctors and his/her staff with respect, express your gratitude for their services and behave in a way that reflects positively on both AOA and your family at all times.**

_____8. Your child may be removed from the program at any time (this includes during the application process, and after treatment has started) if the child or parent/guardian is **uncooperative** or **disrespectful** to AOA staff or doctors, or fails to comply with any Share a Smile rules and guidelines. During the course of treatment, the doctor may, at his/her discretion, refuse to continue treatment and may remove the child's braces. If removed for cause, your child is no longer eligible to reapply to the Share a Smile program.

_____9. Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must not eat hard or sticky foods or pull on the braces. **If there is frequent damage to the braces, the AOA has the option of removing the braces or charging you to repair the damage, which is not covered by this program.**

_____10. One (1) upper and one (1) lower retainer device will be provided as part of the treatment program at no charge. **If this retainer is lost or damaged, you will be charged for a replacement.**

_____11. If your child is accepted into the program, you consent to AOA's use, without charge, of all photos, video or audio recordings of you and your child. AOA may (1) copyright, broadcast, display, publish, re-publish, and reproduce you and your child's image, voice and any statements made by you and him/her, in whole or in part, in any and all media forms; and (2) assign you and your child a fictitious name or use your or his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with Share a Smile, for fundraising or other promotional and advertising purposes. You and your child agree to participate in surveys and case management during and after treatment.

Consent and Hold Harmless Agreement

The undersigned has read, understands and agrees to abide by the attached **Program Rules and Guidelines,** which are incorporated herein by reference, for receiving orthodontic treatment **Austin Orthodontic Arts, PLLC (AOA)**, and has been given the opportunity to ask questions about this information. If our application is approved, I consent to allow Austin Orthodontic Arts, PLLC to provide orthodontic treatment for my child. I understand that acceptance into the Share a Smile program for my child's orthodontic care is based on our (my child's and my) ability to maintain my child's oral health as indicated in the Program Rules and Guidelines and to abide by all the Program Rules and Guidelines. **I also understand that if we do not maintain oral hygiene and abide by the Program Rules and Guidelines, my child will be removed from the program, his/her braces will be removed and treatment will be terminated.** I further agree that if treatment is stopped early and my child is removed from the program for not following the Rules and Guidelines, or for any other reason, we (my child and I) will hold Austin Orthodontic Arts, PLLC and the assigned treatment provider harmless and free from any liability for any damage or injury resulting from the termination of said treatment. I expressly authorize Austin Orthodontic Arts, PLLC and my dentist (as listed on my Dental Referral Form) to share my child's medical records and information with each other in order to coordinate and manage my child's treatment. In consideration of the acceptance of my child's application by Share a Smile, we (my child and I) release Austin Orthodontic Arts, PLLC and its agents, employees, board members, officers, representatives, and successors and assigns from any and all claims, demands, actions, proceedings, damages or liability of any kind whatsoever that we may have at any time arising, directly or indirectly, from (i) our participation in the Share a Smile program, or (ii) any action taken by Austin Orthodontic Arts, PLLC based on the Program Rules and Guidelines, including but not limited to my child's removal from the program and the removal of his/her braces. I further acknowledge and understand that Austin Orthodontic Arts, PLLC does not guarantee satisfaction with the outcome of the orthodontic treatment provided. This Agreement shall be interpreted and enforced in accordance with the laws of the State of Texas and is intended to be as broad and inclusive as permitted by the laws thereof. Waiver of any provision by Austin Orthodontic Arts, PLLC shall not operate or be construed as a continuing waiver. This Agreement shall survive termination or completion of my child's treatment. If any portion of this Agreement is held invalid, the remainder of it shall remain effective.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE CONSENT AND HOLD HARMLESS AGREEMENT.

Custodial Parent or Legal Guardian Consent: I further certify I am the custodial parent or legal guardian for the child named below, that I have legal authority to make medical decisions for the child, that all the information enclosed in this application is true and correct and that all income is reported. I understand that deliberate misrepresentation will not be tolerated and will result in permanent dismissal from the program.

Your signature must be hand written. Electronic signatures are not acceptable.

Date (mm/dd/yyyy) Custodial Parent or Legal Guardian SIGNATURE PRINTED NAME

Child Consent: (Child MUST sign even if under 18 years of age)

Date (mm/dd/yyyy) Child/Applicant SIGNATURE (Not Parent/Guardian) PRINTED NAME