Smile for a Lifetime Foundation of East Contra Costa, California

Application Form (updated 11.2017)

Applicant's Name:_____D.O.B:_____ Gender_____

Name of Parent or Legal Guardian:_____ Relationship to Applicant:_____

Street Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Name of School:_____ How did you hear about S4L:_____

Name of Dentist:_____ Date of Last Visit:_____

Number of times applicant has previously applied for this scholarship: _____

Total Household Income: $_____, number of family members _____

To be considered for the ORTHODONTIC SCHOLARSHIP, you MUST INCLUDE:

1. A copy of last year's tax return, W-2s, or a copy of the most recent pay stubs for all family wage earners.
2. Two 5 x 7 photos of the applicant
    a. One full face photo showing a full smile and the teeth
    b. One close up photo showing the applicant's teeth.
3. Two letters of reference (typed and limited to one page each) from a teacher or community leader that knows the applicant.
4. A copy of applicant's last report card or school transcript.
5. Handwritten answers by the applicant for all the questions on the attached Applicant Questionnaire.

Mail the completed application and all supporting documents to:

S4L Foundation of East Contra Costa County
3428 Hillcrest Avenue, Suite 100
Antioch, CA 94531

For questions: 925-757-3356 or info@Sheffieldortho.com with S4L in the subject line.

Note: Applications, pictures and supporting documents will not be returned, and will become the property of Smile for a Lifetime of East Contra Costa County, California.

Signature of Parent or Legal Guardian:_____ Date:_____

Applicant Questionnaire … TO BE ANSWERED in APPLICANT'S OWN WORDS and HANDWRITING.

1) Tell us about yourself. What do you like to do? What do you like to study in school? What activities or volunteer work do you do outside of school? What would you like to do when you grow up? How are you working toward your goals?

2) Tell us about your family. How many people live with you, and who are they?

3) Why do you want braces? What prevents you from getting braces now? How do you think braces will make a difference in your life now and in the future?

4) We think everyone has the ability to help others. If the Foundation gives you this gift, how will you "pay it forward" and give back to others in the community?

AUTHORIZATION FOR SMILE FOR A LIFETIME, INC., Robert Sheffield DDS, Inc., TO RELEASE NAME, PHOTOGRAPHS, FILMS AND "PHI" TO MEDIA OUTLETS AND SIMILAR PUBLICATIONS

The undersigned hereby authorizes Smile for a Lifetime, Inc., Robert Sheffield DDS, Inc., Robert Sheffield, DDS to release photograph(s), film, and information regarding the patient's treatment, including Protected Health Information ("PHI") pursuant to 45 C.F.R. §164.508(a)(3), for the limited purpose of its newsworthiness to the general public, or for human interest, publicity, marketing and/or advertising, concerning:

Patient's Name:_____

These records may be used for promotional or publicity purposes and may appear in mass media publications, on the Smile for a Lifetime, Inc. or Robert Sheffield, DDS Inc. internet sites, within other such publications or on similar internet sites, shown in television presentations, and released to media outlets. The patient and/or his/her legal representative agree that the patient's identification including the patient's and family's name may be used in such release(s). This release may be revoked by the patient and/or his/her legal representative at any time, in writing. Such revocation shall only be effective to prevent any expanded future use of the information from the date of revocation of said consent. Otherwise, this release shall continue without expiration. The patient and/or his/her legal representative acknowledge that participation in or treatment under the program, Smile for a Lifetime, is not conditioned upon agreeing to sign this release.

The patient and/or his/her legal representative also acknowledge that PHI and other information, photographs, films, and the like used for the purposes sought by this release could be disclosed by others who view it and that the PHI may no longer be protected by 45 C.F.R. §164.508(a)(3). Finally, the patient and/or his/her legal representative acknowledge that they have been provided a copy of the signed release regarding these disclosures.

I/we understand and acknowledge the forgoing. All questions regarding the requested disclosures have been answered and I/we voluntarily agree to the disclosures outlined above without limitation.

_____ _____

Signed (Patient, or Parent or Legal Guardian if Patient is a Minor) Print Name & Date

Address: _____

Phone: _____

Witness Signature: _____ _____

Witness Printed Name & Date

Witness Address: _____

Witness Phone: _____