

***Sunshyne Smiles Program
Orthodontic Assistance Application
(to be completed by parent/guardian)***

Child's Name: _____
(First) (MI) (Last)

Birthdate: _____ Sex: ___ Male ___ Female

Parent/Guardian Name (s): _____
(First) (MI) (Last)

Address: _____ Daytime Phone: _____

City/State/Zip: _____ Other Phone: _____

Number of members in your household Adults: _____ Children: _____

Are Parents/Guardians employed? Father Yes/No
Mother Yes/No

Total Monthly Net Income \$ _____

Total Monthly Expenses \$ _____

Yearly family income for past two years Year: _____ \$ _____
(Please attach copies of IRS Form 1040)

Year: _____ \$ _____

Does your child/family receive Food Stamps? Yes No

Does your child/family receive free or reduced school lunch? Yes No

Does your family receive housing assistance? Yes No

List amount of liabilities:

Mortgage \$ _____
Loans \$ _____
Credit cards \$ _____
Other debt \$ _____

List value of assets:

House \$ _____
Investments \$ _____
Land/Real estate \$ _____
Savings \$ _____
Other \$ _____

Describe any extra ordinary circumstances affecting your child or your family:

***Sunshyne Smiles
Orthodontic Assistance Program
Dental Referral Form***

Date: _____

Patient's Name: _____
(First) (MI) (Last) (Age)

Referring Dentists Name: _____
(First) (Last)

Dentist's Address: _____
(Street) (City) (State) (Zip)

Dentist's Telephone Number: () _____

Reason for the referral:

Assessment:

Malocclusion:	Class I	<input type="checkbox"/>	Class II	<input type="checkbox"/>	Class III	<input type="checkbox"/>
Crowding:	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Spacing:	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Overjet:	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Overbite:	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Crossbite:	Anterior	<input type="checkbox"/>	Posterior	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Good oral hygiene: Yes <input type="checkbox"/> No <input type="checkbox"/>		Caries free: Yes <input type="checkbox"/> No <input type="checkbox"/>		Physically capable of cleaning teeth: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Positive attitude towards dental care: Yes <input type="checkbox"/> No <input type="checkbox"/>		Ability to complete treatment: Yes <input type="checkbox"/> No <input type="checkbox"/>		Keeps scheduled appointments: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Impacted Teeth: Yes <input type="checkbox"/> No <input type="checkbox"/>		Missing Teeth: Yes <input type="checkbox"/> No <input type="checkbox"/>		Length of time patient has received care in your office?		

Please send this form directly to:
 South Dakota Dental Foundation
 PO Box 1194
 Pierre SD 57501

_____ (Referring Dentist Signature)

*Sunshyne Smiles Program
Orthodontic Assistance Application
(to be completed by child)*

Name: _____

My Parents/Guardian: _____

I live at: _____

I go to school at: _____

My Siblings and their ages: _____

My dentist's name: _____

I would like to have orthodontics/braces because: _____

Sincerely,

Name: _____

Sunshyne Smiles

Authorization of Release of Protected Health Information

By signing this document, you are allowing the South Dakota Dental Foundation staff to give or receive your child's health care records to other health care providers in order to provide the best care for your child. The records may be sent to a dentist, orthodontists, or other dental specialist.

Patient's Name _____

Social Security Number _____ - _____ - _____

I hereby authorize:

Sunshyne Smiles Program
C/O South Dakota Dental Foundation
PO Box 1194, Pierre, SD 57501, 605-224-9133

to receive from, or release to, the appropriate health care provider, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian _____
(please print)

Parent/legal guardian signature _____ **Date** _____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

Note: This authorization is valid for four years from date of signature unless revoked in writing prior to that date.

Photo Consent and Release

I consent to the use of pictures of myself, or my child, for program promotion, including print, video and web promotion, events and activities. I also agree that any written information or other material provided by me or my child in connection with the Sunshyne Smiles program may be used in promotional materials, events and activities.

Name of parent/legal guardian _____
(please print)

Parent/legal guardian signature _____ **Date** _____

Sunshyne Smiles Orthodontic Program

The Mission: a state-wide program that assists in providing orthodontic treatment to deserving children who would not otherwise receive care, thus giving them a sense of self worth that will help them improve their lives. This is an innovative approach to providing orthodontic care for a deserving but underserved population.

The Goal: Assist up to 20 South Dakota families annually in providing needed orthodontic care for their children near the area in which the family lives.

The Program: The program is a partnership between of South Dakota Orthodontic Society, The Order of the Eastern Star and the South Dakota Dental Foundation.

The Funding: The seed money for the program is provided: Dr. Mel Thaler of Sioux Falls; the South Dakota Chapter of The Order of the Eastern Star; the State of South Dakota and, the Delta Dental Philanthropic Fund. Funds will continue to be raised from a wide array of donors throughout South Dakota. A major portion of the cost of each orthodontic case is contributed by participating South Dakota orthodontists.

An endowment has been established with the gifts from Dr. Thaler and the Delta Dental Philanthropic Fund. Additional funds will be sought to build the principle of the endowment. Earnings from the endowment are be used to assist with providing orthodontic care. The endowment fund is administered by the South Dakota Dental Foundation and is invested using a trust organization with a history of successfully managing endowments.

Program Administration: The South Dakota Dental Foundation administers the day-to-day operation of the program. Staff and equipment of the South Dakota Dental Association are used to operate the program.

Patient Selection: Patients must be South Dakota residents age 21 or under. Patients must meet the eligibility criteria below, and will be selected to receive care based on the severity of their orthodontic needs, and circumstances preventing them from receiving care through conventional means. A letter from the patient's dentist documenting several of the elements of patient eligibility will be required. The patient's family must complete an application to determine eligibility. An orthodontist will evaluate the orthodontic needs. A selection committee will review all new qualifying applications quarterly for acceptance into the program.

Patient Eligibility:

Oral Health – the patient must have good oral hygiene and no cavities.

Dental Home – the patient must have been under the care of a dentist for at least the past two years. A referral from a general dentist will be needed to be eligible for participation.

Means Test – the patient's family or guardian must demonstrate an inability to pay for the full cost of orthodontic care. The family will be evaluated for both income and assets.

Financial Commitment – the patient's family or guardian must demonstrate the ability to pay approximately \$25 to \$50 per month toward the cost of the treatment.

Readiness – the patient must demonstrate the physical and mental maturity to receive treatment.

Orthodontic Need – the patient must demonstrate a need for orthodontic care, documented by an orthodontic evaluation.

Motivation and Commitment – The patient and the patient’s family must demonstrate an understanding and appreciation for the care they will receive and must be motivated and committed to obtaining the care through the orthodontist who begins the treatment.

Compliance – Once accepted for treatment, the patient and family, must comply with the “rules” established by the orthodontist providing the care. The treating orthodontist can refuse care to any patient who does not comply.

Location Stability - The patient and the patient’s family must commit to staying in the geographic area where the orthodontic treatment was started through the completion of the treatment.

Informed Consent - The patient’s parent or legal guardian will be required to provide informed consent, through a signed statement.

Orthodontists: All orthodontists participating in the program are graduates of an ADA–accredited orthodontic program. Orthodontists participating in the program are located throughout the state of South Dakota.

Operations: Once a patient is accepted for treatment, they begin to make regular monthly, or quarterly payments to the Foundation. These payments may begin as early as a year prior to the beginning to treatment. Participating orthodontists receive payment through the Foundation in three equal payments - one at the beginning of treatment and two payments each of the following two years. Patients are referred to an orthodontist based on geographic accessibility, and availability. A participating orthodontist may chose to accept or decline a patient after conducting an evaluation and holding a consultation with the patient and the patient’s family.

Cost of Care: Participating orthodontists receive approximately half* of their normal fee from the Sunshyne Smiles Program for each case they treat. The families contribute approximately \$25 to \$50 per month to the program toward the cost of the treatment over the course of 36 months. A sliding fee scale is use to determine the contribution from the patient or the patient’s family. The program assumes the difference between the family’s contribution and the amount committed to the orthodontist.

Other Payers: If the patient has insurance with an orthodontic benefit or Medicaid, those resources will be fully utilized prior to any assistance through the Sunshyne Smiles Program.

Family’s Financial Contribution: A sliding fee scale is used to determine the monthly contribution of the families participating in the program. The sliding scale is a guide, to assist in determining a family’s contribution, and consideration of a lower monthly contribution will be considered in special circumstances. Additionally, other sources of funding may be available to assist families unable to meeting the monthly contribution. The sliding scale, based on the family’s annual income as a percent of the Federal Poverty Levels, is as follows:

Family’s Annual Income	Monthly Contributions	Total Contribution
0 - 150 %	\$25	\$ 900
150 - 250%	\$50	\$1,800

* Participating orthodontists may elect to receive less than two-thirds of their normal fee in order to assist the program during its early years of operation.