Give Back A Smile Applicant Instructions

Please keep this page for your future reference and records

1. Read the Give Back A Smile (GBAS) application carefully before filling out.
2. Your application will be returned if all pages are not completed and the application is not signed and dated.
3. Make an appointment with a counselor, domestic violence advocate, social worker, minister or therapist and have him/her complete the advocate section of the application (Page 6).
4. **Make a copy** of the completed application for your files.
5. **Mail the completed application to GBAS, 5401 World Dairy Drive, Madison, WI 53718 or fax it to 888.488.6888.**
6. Once your application is complete and has passed the initial review, you will be sent a letter within 30 days informing you of your case status. Please note that, by completing an application, you are not guaranteed admission to the program.
7. If your **address or phone number changes**, you must notify GBAS by calling 800.543.9220 or e-mailing givebackasmile@aacd.com. All changes must be made directly with the GBAS office. **No returned mail will be forwarded.**
8. GBAS conducts the initial review of the application; however, the **dentist makes the final decision of eligibility based on our guidelines**. This is a volunteer program and the dentist decides what procedures fit within the guidelines. You are **not accepted** into the program until such time as the dentist conducts an initial consultation and develops a treatment plan, and you may be disqualified from the program at any time for any reason or no reason at all.

YOU MUST MEET THE FOLLOWING GUIDELINES TO QUALIFY:

1. You must have received injuries or damage to your smile-zone (the teeth that show when you smile) from an abusive intimate partner or spouse; husband, wife, partner, boyfriend, girlfriend, someone you have dated or with whom you had a child. These injuries can result from neglect, if your partner withheld funds or access to dental care. Other situations, while traumatic, do not qualify. If the injury was caused by child abuse, elder abuse, sibling abuse, caregiver abuse, parent abuse, violent attacks not related to intimate partner violence, stranger assault, or accidental injury, the application will be denied.
2. Any other dental conditions present such as dental disease, cavities or gum disease, even if such conditions are due to neglect are not covered by this program.
3. You must be out of an abusive relationship for at least one year before you are eligible to participate in the program. An exception for less than one year may be granted if the abuser is deceased or in jail. If the abuser is in jail, you must include an expected date of release in your application.
4. You must see a domestic violence advocate, social worker, counselor, minister, or therapist at least once. The application will be returned if the advocate section (Page 6) is not thoroughly completed. Contact the National Domestic Violence Hotline at 800.799.7233 for the phone number of the nearest domestic violence agency.

Give Back A Smile Patient Agreement/Expectation Form

Welcome to the American Academy of Cosmetic Dentistry Charitable Foundation (AACDCF). Members of the AACD are among the most highly trained cosmetic dentists in the world. The mission of the AACD dentist is to generously give back to their community by providing free cosmetic dental care to survivors of intimate partner violence that have had their smiles damaged from physical abuse or have had dental care access withheld as a form of emotional abuse. The intention of this program is to restore the teeth in the smile-zone which show when you smile. Please be aware that all the dentistry you receive from your cosmetic dentist is completely donated to you. The dentist receives no reimbursement for supplies and office staff donate their time. Most of the laboratory work is also generously donated. If accepted into the GBAS program, and at completion of receiving your new smile, please consider writing a letter of appreciation to your dentist.

Please initial on the line next to each of the guidelines and sign below indicating that you understand and will comply with the GBAS Guidelines.

_______ I understand the GBAS volunteer dentist makes the final decision of eligibility according to the program guidelines and determines which procedures fit within the program. Dental treatment is ***not guaranteed*** and I hereby release and waive any and all claims against the AACDCF, my dentist and the GBAS that may arise with respect to my participation in the program.

_______ I understand the GBAS Program ***does not*** cover severe dental neglect, decay, jaw injuries, pre-existing gum disease, or orthodontic treatment. I understand the treating dentist makes the final determination of these guidelines.

_______ I understand the program guidelines ***do not*** allow for the repair or replacement of previous dental work, such as a pre-existing root canal treated tooth, an implant placed in the smile-zone or a fixed or removable prosthesis that is lost or ill-fitting.

_______ I understand the GBAS program does not guarantee patient requested treatment plans, i.e. implants, orthodontics, or oral surgery procedures.

_______ I understand the GBAS program is a volunteer program for which the dentist and staff have donated time and resources. Any needed changes to my scheduled appointment requires at least 48 hours advance notice to the dentist's office.

_______ I understand that, among other reasons, I may be ***disqualified*** from the GBAS program at any time for any of the following: failing to show up for appointments, cancelling appointments, cancelling appointments without 48 hour notice, not maintaining contact with the volunteer dentist or the GBAS office, or not calling to schedule my first consultation appointment within 30 days.

_______ I will update the GBAS office of any contact changes to my phone number or mailing address. I understand that if I fail to do so, and if the GBAS office is unable to locate me, I will be ***disqualified*** from the program. All changes must be sent directly to the GBAS office. No returned mail will be forwarded.

_______ I understand once my GBAS case has been completed the treating dentist is ***not required*** to perform maintenance on the dental work performed nor will my GBAS case be reopened for any reason.

_______ I understand my application will be processed as quickly as possible. **I will refrain from calling the GBAS office to check my application status.**

I have read this agreement form and understand that failure to comply with these guidelines will disqualify me from the program.

_______________________________ _______________________________

Signature Date

FOR GBAS OFFICE USE ONLY

Date Received: ______________ **Authorization Code: ______________**

If you need help filling out the application, check one of the following:
Si usted necesita que alguien ayude a llenar la aplicación, verifica uno de los siguiente:

_____ English is not my native language and I need a translator.
Ingles no es mi idioma nativo y Yo necesito una traductora.

_____ Physical or literacy challenges make it difficult to fill out the application alone.
Los Desafios de alfabetismo y problemas physicales hacen dificile llenar la aplicación sola.

Name of Helper: ________________________________
Nombre de la persona que le ayudo llenar la llenar la aplicación.

Phone Number of Helper: _____________
Numero de telefono

If your address, e-mail address, or phone number changes, you must notify GBAS as soon as possible at 800.543.9220 or your case will be closed. All changes must be directly made to the GBAS office. No returned mail will be forwarded. If you do not have a phone, please write down a contact phone number where we can leave a message for you.

PLEASE PRINT

1. First Name: ____________________ Middle Initial: ____ Last Name: _____________________
2. Mailing Address:
   Street: ____
   City: ___________________________ State: ___________________ Zip Code: ____________
3. Home Phone: ___________________________ Other Contact Phone:______________________
4. E-mail Address: ____
5. Are you willing to travel? (circle one) **Yes** **No** **If yes, how far?_________miles**
6. Did you receive dental injuries from a former intimate partner or spouse? (circle one) **Yes** **No**
7. Please list the date of separation from your abuser: MONTH: _______________ YEAR: ________
   If less than one year from today and if your abuser is deceased or imprisoned check one:

   ____ abuser is deceased____ abuser is imprisoned If so, release date: _________

8. Have you had prior dental procedures performed after the injury to your teeth? (The program guidelines **do not** allow for the repair or replacement of dental work performed after experiencing the injury.

   (Circle one) **Yes** **No** Date: ____________________

   If YES, explain: ____

9. Describe the injury to your teeth (The program guidelines *do not* **cover dental neglect, decay, jaw injuries, pre-existing gum disease, or orthodontic treatment**). IF POSSIBLE, PLEASE INCLUDE A PHOTO OF YOUR DAMAGED TEETH.

   Date of injury: ___________ How many teeth are missing? _________________

   Do you have broken or damaged teeth? ______

   Description of injuries to the teeth: ____

   ____

   ____

10. ***I verify the statements on this application are true. I authorize the release of this information to the AACD, the Give Back A Smile program, and the dentists providing dental care needed.***

    To the facilitate completion of my case, I understand the information I provide may be shared with the proper dental facilities necessary.

SIGNATURE: ____ Date: _______________

Advocate Section

This section must be filled out by your advocate and included with your application in order for you to be considered for this program.

For verification that the dental injuries were caused by intimate partner violence and that you are now out of an abusive relationship, this page must be filled out by one of the following: counselor, domestic violence advocate, social worker, therapist or minister.

You can either see someone you have talked with in the past or seek a referral to a local domestic violence program. For the phone number to a local domestic violence program, call the National Domestic Violence Hotline at 800.799.7233.

If the counselor, advocate, social worker, therapist, or minister needs more information about the program prior to completing the application, contact GBAS at 800.543.9220.

Advocates: Please indicate your role by circling the one that best applies to your position:

Counselor   Advocate   Social Worker   Therapist   Minister   Other

Comments: ____

____

____

____

____

____

____

____

____

I confirm that I have met with the applicant at least once. Based solely on her/his explanation, I believe her/his injuries were caused by intimate partner violence, and that she/he is now out of the abusive relationship. I understand that I may be contacted to verify my place of employment and signature.

Signature: ____ Date: ______________________

Print Name: _________________________________ Agency: _____________________________

Phone: ____________________________ Address: ____________________________________

City: ____________________________ State: __________________ Zip Code: ______________

Please mail pages 2-6 to: GBAS, 5401 World Dairy Drive, Madison, WI 53718

Or fax to: 888.488.6888