**Tomorrow’s SMILES® Program**

Do you know a **promising teen whose future is at-risk due to lack of dental treatment**? Would your teen and his or her family understand, appreciate, and value pro-bono dental care? If so, your teen may qualify for the National Children’s Oral Health Foundation’s **Tomorrow’s SMILES® Program**.

**Did You Know?**
- Dental decay is the #1 chronic childhood disease.
- Each year, American children and teens miss more than 51 million school hours due to pain associated with preventable dental disease.
- While in school, children and teens with dental issues are distracted by pain and embarrassment. This puts them at a greater risk for performing poorly.
- A healthy smile can positively affect the ability of teens to communicate confidently with peers, teachers, and potential employers.

**How does the Tomorrow’s SMILES® Program address a teen’s need for dental care?**
- NCOHF’s **Tomorrow’s SMILES® Program** matches at-risk teens with local dental providers who will provide them with quality, pro-bono dental care.
- With the assistance of a parent or guardian, teens complete the **Tomorrow’s SMILES®** application. Teens are expected to submit an essay and photograph as part of the application.
- Teens identify a sponsor. The sponsor will submit a formal recommendation of the teen to the program.
- If selected, NCOHF works to identify a local dentist who agrees to treat the teen pro-bono. Note that admittance to the Program does not guarantee that a dental provider will be found. If a match is made, NCOHF will provide the teen and his/her sponsor with the dental provider’s contact information.
- The teen is expected to make dental appointments, communicate with the dental provider, avoid missing appointments, and follow through on the treatment plan. The sponsor is expected to support the teen throughout this process.
- During treatment, the teen and sponsor will communicate with NCOHF regarding treatment progress through submission of electronic survey forms.
- During treatment, the teen will Pay It Forward by becoming an Oral Health Activities Leader in their community. Fulfilling these responsibilities will serve as demonstration of appreciation for the dental care received.
- After treatment, the teen will submit a photograph to NCOHF. Both sponsor and teen will submit post-treatment electronic survey forms.
Tomorrow’s SMILES® Program

Application Overview

The following information must be completed and returned to Katharine Correll, Tomorrow’s SMILES Program Manager, for review.

1. **Form 1:** Application, 3 pages total. All applicant’s must be age 12-19 and enrolled in school. The parent/legal guardian must complete the Tomorrow’s SMILES® Program application if the applicant is 12-17 years old. If the applicant is 18 or over, he/she may complete the application independently.

2. **Form 2:** Sponsor Agreement and Recommendation Form. The applicant must submit a letter of recommendation from an advocating sponsor. The sponsor may be a school principal, nurse, guidance counselor, teacher or advisor.

3. **Form 3:** Applicant Essay/Photograph Form. Essay to be completed by the applicant on a separate sheet(s) of paper. Photographs can be submitted with application via mail or electronically.

4. **Form 4:** Pay It Forward Agreement Form. This must be signed by applicant and sponsor to indicate that the applicant understands his/her responsibilities to Pay It Forward as an Oral Health Activities Leader in his/her community.

5. **Form 5:** 24-Hour Notification Agreement Form. This must be signed by applicant and sponsor to indicate that both individuals understand the importance of maintaining open lines of communication between the applicant and volunteer dental provider throughout the course of treatment.

6. **Form 6:** Waiver/Release Form. This must be initialed and signed by the parent/legal guardian along with a witness’s signature.

This program will cover applicants with or without Medicaid insurance who meet all eligibility requirements.

Applications must include all required documents in order to be processed and are reviewed on a monthly basis. Please return ALL forms and photos to:

National Children’s Oral Health Foundation: America’s ToothFairy

Tomorrow’s SMILES® Program

4108 Park Road, Suite 300
Charlotte, NC 28209
Phone (704) 350-1600 Fax: (704) 350-1333
Or Email to: kcorrell@ncohf.org
**Tomorrow's SMILES® Program**  
**Application ~ For those age 12-19**

**APPLICANT INFORMATION ~** Completed by parent or legal guardian if applicant is 17 years old/under. Incomplete applications will not be accepted. Please pay particular attention to those parts in **BOLD**.

Today’s Date: ______________________

Applicant’s full legal name: _______________________________________________________

DOB: _______________  ☐Male  ☐Female  Nickname ___________________________

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Home Phone: ( _____ ) _____ - ______  Cell Phone: ( _____ ) _____ - ______

**Applicant E-mail address:**

**If the applicant has an e-mail address, please provide**

Parent E-mail address: ___________________________________________________________

Father’s name: ____________________________Are you employed: ☐Yes  ☐No

If yes, Employer _______________________________________________________________

Mother’s name: ____________________________Are you employed: ☐Yes  ☐No

If yes, Employer _______________________________________________________________

Legal Guardian’s Name: ____________________________Are you employed: ☐Yes  ☐No  
*(If different than parent)*

If yes, Legal Guardian Employer’s Name: ___________________________________________

**FORM 1: Tomorrow’s SMILES® Program**  
**Application – page 1 of 3**
Tomorrow’s SMILES® Program
 Applicant Medical/Dental Information

**Medical History**

Physician’s name: ____________________________________________________________

Physician’s address: __________________________________________________________

Physician’s phone: ___________________________________________________________

State of general health: _______________________________________________________

Medical conditions/diagnoses your dental provider should know about:

____________________________________________________________________________

Are you on any medications:  □ Yes  □ No

If yes, list medications: _______________________________________________________

Are you allergic to any medications? □ Yes  □ No

If yes, list: __________________________________________________________________

**Dental History**

Dentist’s name: ______________________________________________________________

Dentist’s address: _____________________________________________________________

Dentist’s phone: _______________________________________________________________

Date of last dental exam: _______________  Location: _________________________________

______________________________________________________________________________

Dental Insurance: □ Yes  □ No  Medicaid: □ Yes  □ No

If yes, list dental insurance provider: _____________________________________________

Insurance or Medicaid Identification number: _________________________________

Group number: __________________________________________________________________

FORM 1: Tomorrow’s SMILES® Program
Application – page 2 of 3
I acknowledge that the information I have given is true and correct.

<table>
<thead>
<tr>
<th>Monthly Expenses</th>
<th>Amount</th>
<th>Monthly Income</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Mortgage or Rent</td>
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<td>Wages</td>
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<td>Utilities</td>
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<td>Unemployment</td>
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<td>Food</td>
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<td>Car Payment</td>
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<td>Car Insurance</td>
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<td>Child Support</td>
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<tr>
<td>Other</td>
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<td>Other</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>Total</strong></td>
<td><strong>Total Income</strong></td>
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</tr>
</tbody>
</table>

Please list for each of your children:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date</th>
<th>School</th>
<th>Grade</th>
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Parent/Legal Guardian signature __________________________________________
Date:____________
Relationship or title ______________________________________________________

FORM 1: Tomorrow’s SMILES® Program
Application – page 3 of 3
Tomorrow’s SMILES® Program
Sponsor Agreement and Recommendation Form

The applicant or applicant’s parent or legal guardian must identify an advocating sponsor. The sponsor will act as a liaison between NCOHF and the applicant throughout the course of dental treatment. A sponsor’s responsibilities include ensuring that the applicant attends dental appointments, maintains open lines of communication with his/her dental provider, and fully carries out his/her role as an Oral Health Activities Leader. An advocating sponsor may be a school principal, nurse, guidance counselor, teacher, youth or advisor.

The sponsor is required to write a letter of recommendation on the applicant’s behalf. It must address the prompt below. Please attach this letter to the application. This letter must state the sponsor’s relationship to the applicant and why the sponsor believes the student should be approved to be a Tomorrow’s SMILES® recipient.

1. As a sponsor, please state your relationship to the applicant. Why are you referring this individual to the Tomorrow’s SMILES® program? Why should the individual be approved to be a Tomorrow’s SMILES® recipient?

Applicant’s Name (print):__________________________________________________________

Sponsor’s Name (print):__________________________________________________________

Sponsor’s Signature:______________________________________________________________

Sponsor’s phone number: ( ____ _____ ) ____ ____ - ____ ____ ____ Ext. ________

Sponsor’s e-mail address:__________________________________________________________

**Providing an e-mail address is required**
Tomorrow’s SMILES® Program

Applicant Essay Requirement

Please answer the following essay questions on a separate sheet of paper:

1. Please describe your smile

2. Please explain how changing the appearance of your smile will make a difference for you

3. Please describe your career goals and plans you have to achieve your goals.

4. Who will support you during this process to see that you follow treatment, make it to appointments and carry out your responsibilities as an Oral Health Activities Leader?

APPLICANT PHOTOGRAPH REQUIREMENT

Please include a headshot of the applicant smiling with teeth showing. If the applicant is accepted in the program, this will be his/her “before” photo. We understand that, for some applicants, taking a photograph may produce feelings of uneasiness. Please know that the applicant’s photo will help us tell his/her story to our volunteer dentists and select the best dentist for each applicant depending on individual needs.
Tomorrow’s SMILES® Program
Pay It Forward Agreement

**Applicant:** The Pay It Forward mentoring opportunity will serve as demonstration of appreciation for dental care received. To pay it forward, you will assume the role of an Oral Health Activities Leader in your community. Fulfilling the responsibilities of an Oral Health Activities Leader will help to break the cycle of preventable pediatric dental disease by providing interactive, engaging and informative lessons and activities to a younger population.

Please initial next to each item to acknowledge that you have read and understand the responsibilities of Paying It Forward by being a Community Oral Health Activities Leader. You must complete all responsibilities to receive dental care through Tomorrow’s SMILES.

As an Oral Health Activities Leader, I will:

_____ Provide NCOHF with electronic feedback on my own oral health awareness and habits throughout treatment. This includes updating NCOHF on my treatment progress. I understand that my sponsor or I will receive links to these electronic forms via e-mail.

_____ Schedule and complete 3 Community Education Kit presentations to members of my local community (school, church, Boys and Girls Club, etc).

_____ Provide NCOHF with electronic feedback after the Community Education Kit presentations. I understand that my sponsor or I will receive links to these electronic forms via e-mail.

_____ Participate in 2 Activities from the Youth Activities Guide. One of these activities will be the “My Smile Matters” Advocacy Contest.

Applicant’s Signature: __________________________________________   DATE

**Sponsor:** Please sign below to indicate that you have reviewed the responsibilities of an Community Oral Health Activities Leader with the applicant and that you will help the applicant fulfill them.

Sponsor’s Signature: __________________________________________   DATE

**It is suggested that you retain a copy of this page for your records to track the responsibilities that you have and have not fulfilled should NCOHF request this information.**

Form 4: Tomorrow’s SMILES
PIF Agreement – Page 1 of 1
Tomorrow’s SMILES® Program
24-Notification Agreement

We acknowledge that the Tomorrow’s SMILES® Program volunteer dentist is providing pro-bono services and understand the value of his/her time.

We agree to give the Tomorrow’s SMILES® Program volunteer dentist a minimum of 24-hour notice if an emergency arises and we are unable to make a scheduled appointment. We understand that failure to give the dentist adequate notice may result in the termination from the program.

Applicant’s Name: ___________________________________________________
please print

Applicant’s Signature: ______________________________________________

Parent/Guardian’s Name: _____________________________________________
please print

Parent/Guardian’s Signature:_________________________________________
**Initial each item**

_____ We acknowledge that the Tomorrow’s SMILES volunteer dentist is providing pro-bono services and understand the value of this/her time. We agree to give the Tomorrow’s SMILES volunteer dentist a **minimum 24-hour notice** if an emergency arises and we are unable to make a scheduled appointment. **We understand that failure to give the dentist adequate notice may result in dismissal from the program.**

_____ We acknowledge that he/she understands treatment is provided by a volunteer professional through his/her association with the National Children’s Oral Health Foundation Tomorrow’s SMILES® Program and treatment is at the patient’s own risk.

_____ We hereby release and discharge the National Children’s Oral Health Foundation and any dental professional participating in the Tomorrow’s Smiles® Program from all liability and claims arising out of or related to the selection of any dentist or the provision of services by that dentist. This release is freely and voluntarily given.

_____ We grant permission to the National Children’s Oral Health Foundation and any dental professional participating in the Tomorrow’s SMILES® Program to use my/my youth’s image, voice, and/or words in informational materials such as reports, brochures, videos, etc. I waive all claims for compensation and release the National Children’s Oral Health Foundation from any liability related to such use.

_____ Volunteer dental professionals providing treatment through National Children’s Oral Health Foundation: *America’s ToothFairy* Tomorrow’s SMILES program, are authorized to release protected health information about the above named patient to the representative for Tomorrow’s SMILES.

_____ We agree that our child will participate in the Tomorrow’s SMILES “Pay It Forward” program by delivering engaging educational oral health activities and lessons, provided by NCOHF, to younger children to help break the cycle of this preventable disease for future generations.

__________________________
Signature of Parent/Guardian  (The applicant may sign for themselves if over 18 years old.)

__________________________
Printed Name of Signatory

__________________________
Date of Signature

__________________________
Witness Signature

__________________________
Printed name of witness and contact phone and email