



2018 APPLICATION FORM

Smiles4Canada is a program of the Canadian Foundation for the Advancement of Orthodontics (CFAO) in conjunction with the Canadian Association of Orthodontists (CAO)

A. Patient Information Form

Candidate's Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Street Address: _____

City/Town: _____

Province: _____

Postal Code: _____

Phone Number: _____

E-mail Address: _____

How many years has the candidate lived at this address? _____

Number of children in the candidate's family, including the candidate: _____

Number of parents and/or guardians in the candidate's family: _____

Please list all of the parents and/or guardians that are responsible for the candidate (may or may not live with the Candidate):

Parent/Guardian #1

Full Name: _____

Relationship to Candidate: _____

Street Address: _____

City/Town: _____

Province: _____

Postal Code: _____

Phone Number: _____

E-mail Address: _____

Parent/Guardian #2

Full Name: _____

Relationship to Candidate: _____

Street Address: _____

City/Town: _____

Province: _____

Postal Code: _____

Phone Number: _____

E-mail Address: _____

Are parents: Married/Living together? Divorced? Separated? Remarried? Widowed?

B. Financial Information Form

Please provide the Net Income for each of the 2 most recent years for each of the candidate's parents/guardians. This information is shown on the Canada Revenue Agency (CRA) Notice of Assessment (NOA).

Please be advised that this information will remain confidential and will only be used by the Regional Committee to evaluate the financial need of the family.

Please provide one copy of each parent/guardian's 2016 & 2015 NOA and attach to this application form.

Parent/Guardian #1

Taxable Income from 2016 (Line 260) _____

Minus: Total Tax Payable from 2016 (Line 435) _____

Equals: After Tax Income from 2016: _____

Taxable Income from 2015 (Line 260) _____

Minus: total Tax Payable from 2015 (Line 435) _____

Equals: After Tax Income from 2015: _____

Parent/Guardian #2

Taxable Income from 2016 (Line 260) _____

Minus: Total Tax Payable from 2016 (Line 435) _____

Equals: After Tax Income from 2016: _____

Taxable Income from 2015 (Line 260) _____

Minus: total Tax Payable from 2015 (Line 435) _____

Equals: After Tax Income from 2015: _____

1. Do you have any Orthodontic Insurance? Yes No

If yes, Name of Insurer: _____

2. Have you applied to other programs? Yes No

If yes: NIHB Smiles Change Lives Other: _____

Have you been accepted? Yes No Still waiting

3. Has your child had a consultation with an Orthodontist? Yes No

If yes, name of Orthodontist: _____

4. Do you currently have a signed contract with an Orthodontist for treatment? Yes No

If yes, name of Orthodontist: _____

C. Personal Statement Form - to be Completed by the Candidate

The Personal Statement must be handwritten and answered by the candidate. Please answer the following questions:

1. How do you feel about your smile now? How do you think braces will improve your life now and in the future?

2. Tell us about yourself. What do you like to do? (Hobbies, interests, school activities, family, friends)

3. Following the *Pay It Forward* philosophy, if you had a chance to do a favour for another person or organization, without hope of being paid back, what would you do and why?

D. Digital Photos Guide

We require at least 6 photos to help us evaluate the severity of the dental problems. These can be taken with any digital camera. Descriptions of the 6 necessary images are below. Please feel free to include additional photos.

These images must be e-mailed to administration@smiles4canada.ca with the candidate’s name in the subject field; alternately, they can be included with the application on a USB memory stick or on a CD. Below are samples of the types of photos we require. Please note you must send full-size, clear well lit images as part of your application. Applications submitted with only printed photos will not be reviewed.

Image #1 – Portrait from the front with lips at rest



Image #2 – Portrait photo from the front with a smile showing teeth



Image #3 – Profile photo from the side with the lips at rest



Image #4 – Photo of the teeth from the front with the teeth together fully, while biting on the back teeth (You may use your fingers to help move the lips out of the way)



Image #5 – Photo of the upper teeth from the front with the mouth wide open (You may use your fingers to help move the lips out of the way)



Image #6 – Photo of the lower teeth from the front with the mouth wide open (You may use your fingers to help move the lips out of the way)



E. Personal Reference Form

We require a personal reference from someone who knows the candidate well. Any adult non-relative can act as a personal reference. This might be a teacher, principal, coach, social worker or religious leader. A relative/guardian of the candidate **cannot** provide a personal reference.

Please give a copy of this page to the person providing the personal reference. It provides a brief outline of Smiles4Canada and the expectations of the personal reference.

Smiles4Canada is a program run by the Canadian Foundation for the Advancement of Orthodontics (CFAO) in conjunction with the Canadian Association of Orthodontists (CAO). The program provides access to orthodontic care for low-income young Canadians who would otherwise not be able to receive treatment. Applications are evaluated by a Regional Committee that assesses the financial status of the family, the severity of the dental problems, and the character of the applicant. Orthodontic treatment is provided by participating orthodontists who have agreed to donate their services to this worthwhile program. Participating orthodontists receive no compensation, other than the satisfaction of helping a deserving young individual. We are asking for your input to help us determine if the applicant is truly worthy of this program and if s/he will see his/her treatment through to completion.

Your personal information should include:

1. Name of the applicant
2. Your name
3. Your position/occupation
4. Your address
5. Your phone number
6. Your e-mail address
7. Your relationship to the applicant
8. How long you have known the applicant
9. The way(s) you think the applicant is affected by his/her teeth and smile
10. Your description of the applicant's character, and his/her willingness to persevere through a long process, and, if you are aware of one, an instance when s/he has done so.
11. Whether you would recommend the applicant for treatment through Smiles4Canada

Please limit the personal reference to one page. You should sign the personal reference, seal it in an envelope, sign it again over the seal of the envelope and return it to the applicant for submission to the program. Please note you should not discuss the letter or share the contents with the child or his/her parent/guardian.

Thank you for your help with this application. If you have any questions about the program or the personal reference, please visit www.smiles4canada.com or contact us by e-mail at: administration@smiles4canada.ca



*A Program of the Canadian Foundation for the
Advancement of Orthodontics*

2800 14th Ave., Suite 210, Markham, ON L3R 0E4

Email: administration@smiles4canada.ca

Tel: 416-491-3186

F. Program Rules, Expectations and Release Form

Successful Orthodontic treatment requires a significant amount of patient and family cooperation. This form outlines the rules of the program and some of the expectations of treatment. **The parent/guardian submitting this form must read and initial each point to signify agreement with each point before the application will be considered.**

Program Rules/Treatment Expectations

**Parent/
Guardian Initials:**

Smiles4Canada covers the cost of orthodontic treatment only. Other dental treatment may be required for the orthodontics to be completed. This may include cleanings, fillings, extractions, gum surgery, root canals or jaw surgery. Smiles4Canada does not cover the cost of these other dental procedures. You and the patient agree to undertake the necessary treatment so that orthodontic treatment can proceed.

Orthodontic treatment can only be completed in the presence of ideal oral health. The patient is expected to maintain regular appointments with his/her general dentist and to comply with any treatment recommended by his/her general dentist.

The patient is expected to keep his/her mouth clean during orthodontic treatment. This reduces the risk of cavities and gum problems. If the treating orthodontist does not believe the mouth is being kept clean enough, treatment will be stopped and the braces will be removed.

The patient is expected to see his/her orthodontist regularly. This allows treatment to progress and reduces the risk of unwanted tooth movement. If the treating orthodontist finds the patient is not attending regular appointments, treatment will be stopped and the braces will be removed.

The patient is expected to follow the orthodontist's recommended treatment. The patient may be expected to wear rubber bands to help fix the position of his/her teeth. If the treating orthodontist does not believe the patient is wearing the rubber bands as required, treatment will be stopped and the braces will be removed.

The orthodontic office will make other recommendations regarding keeping the mouth healthy and clean, foods and drinks to avoid, emergencies with the braces, and appointment schedules. The patient agrees to follow all of the recommendations and policies of the orthodontic office.

The patient will be expected to wear retainers following orthodontic treatment. If the retainers are not worn as recommended by the orthodontist, the teeth will shift back to their original positions. The patient agrees to wear the retainers as recommended by the orthodontist.

The treatment provided through Smiles4Canada includes the cost of one set of retainers. If the retainers are damaged or lost, or simply wear out over time, a replacement set of retainers will be required. There will be an additional cost for any replacement retainers.

The orthodontic treatment will be provided by one orthodontic office. If the patient moves and is no longer able to visit the original office, Smiles4Canada may **attempt** to find another orthodontic office to complete the treatment; however, Smiles4Canada cannot guarantee that a new office will be found. If Smiles4Canada cannot find an orthodontist to complete the treatment, the patient will be responsible for finding his/her own way to complete the treatment, including any costs involved.

The patient will be expected to complete a short report at the end of his/her treatment, outlining how orthodontic treatment has helped him/her. The patient agrees to complete the report within 3 months of the completion of treatment.

F. Program Rules, Expectations and Release Form (Continued)

I, the parent/guardian of the candidate, confirm the information provided in this application is accurate and complete. The application fully discloses all sources of financial support for the candidate and the family, and all relevant health information relating to the candidate. _____

If the candidate is accepted for treatment, I, the parent/guardian of the candidate, agree to pay a one-time administrative fee of \$500 + HST **before** treatment is commenced. I understand that treatment will not take place until this fee is paid in full and that, once treatment has commenced, the fee will not be refunded under any circumstances whatsoever. This includes if the braces are removed early for any of the reasons mentioned above. _____

If the applicant is accepted for treatment, I, the parent/guardian of the applicant, consent to the use of his/her name, case history, images and testimonial to help promote the program. This may include postings on the program’s website and/or other promotional materials. _____

If there are more than one parents/guardians, I, the parent/guardian of the applicant certify that I have discussed this application with the other parent(s)/guardian(s) and that they have consented to submission of this application. _____

I, the parent/guardian of the candidate, recognize and acknowledge that if we undertake paid orthodontic treatment for the candidate with any orthodontic or dental professional, our application to Smiles4Canada will be invalidated and will not be eligible for the program. _____

By signing this form, you consent to act as the primary contact between Smiles4Canada and the candidate. Other family members who may attempt to communicate with Smiles4Canada will not receive a response. _____

By signing this form, you confirm that the family does not have the financial resources to afford treatment and that they have no way to proceed with threatment unless they are accepted into the program. _____

Name *(please print)*: _____ Signature: _____

Date: _____ Email Address: _____



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G. Dental Examination Form - to be Completed by the Candidate's General Dentist

In order to apply for orthodontic treatment through Smiles4Canada, we require the candidate's general dentist to complete this short form. This will help ensure the candidate's teeth are healthy and that his/her oral hygiene is adequate for orthodontic treatment to be completed.

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Patient's Name: _____

Dentist's Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: _____ E-mail: _____

How long has the patient been under your care? _____

Last regular cleaning/check up: _____

Please rate the patient's prior caries rate: *Very Low* *Low* *Average* *High* *Very High*

Is the patient currently caries free? Yes No

Please rate the patient's oral hygiene: *Very Low* *Low* *Average* *Good* *Very Good*

Do you believe the patient's oral health and hygiene are adequate for orthodontic treatment? Yes No

Would you recommend this patient for treatment through Smiles4Canada? Yes No

Please rate the patient's malocclusion: Severe Moderate Not Severe

Overbite / Overjet? _____

Molar Class? _____

Will surgery be required prior to orthodontic treatment? Yes No Type: _____

Is there anything else you would like the Committee to know as they are evaluating the patient's case?

Signature of Dentist

Date _____



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