

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. Your application will be returned if all pages are not completed and the application is not signed and dated.
2. In order to apply for the GBAS program, **one** of the following **must** be fulfilled:
 - **Include a \$20.00 application fee paid by money order only, to the GBAS program.** Your \$20.00 will help cover the costs of application processing and other survivors of domestic violence enrolled in the GBAS program. **The \$20.00 is nonrefundable as services are not guaranteed.**
 - OR-
 - **Complete 10 hours of community service before submitting your application.** Community service can be performed at the non-profit organization of your choice and the service verification form (page 7) must be completed.
3. **Mail the completed application to GBAS, 402 West Wilson Street, Madison, WI 53703 or fax to 888.488.6888. Please DO NOT fax your completed application if including a money order.**
4. 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 services.
5. 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) **only**, from a former abusive intimate partner or spouse; husband, wife, partner, boyfriend, girlfriend, someone you have dated or with whom you had a child. Emotional abuse is taken into consideration. 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 incarcerated. If the abuser is incarcerated, you must include an expected date of release in your application. If **you** are currently incarcerated, you are welcome to apply once you have been released.
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

The intention of this program is to restore the teeth in the smile-zone only. Please be aware that all the dentistry you receive from your cosmetic dentist is completely donated to you. The dentist receives no reimbursement for time or supplies. 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 that my GBAS application processing fee is nonrefundable even if my application is not accepted for the program or if my case becomes closed.
- _____ I understand that eligible GBAS applicants have dental needs *only* to the teeth that show when you smile.
- _____ 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, misconduct towards the GBAS or dental office staff, 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: _____

 Money Order Received Community Service Verification Received**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 physiques hacen dificil llenar la aplicación sola.

Name of Helper: _____

Phone Number of Helper: _____

*Nombre de la persona que le ayudo llenar la llenar la aplicación.**Numero de telefono*

Please note: In order to apply for the GBAS program, you must send in a \$20.00 application fee, or complete ten hours of community service (see page 1, number 2 for details). The fee or service verification form must be included with your application, or it will be returned to you.

PLEASE PRINT

1. First Name: _____ Middle Initial: _____ Last Name: _____

2. Mailing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

3. 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 (**Required**): _____

8. Have you had any dental work performed to your damaged teeth (i.e. root canal, bonding, bridge, and etc.)?

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

If YES, explain: _____

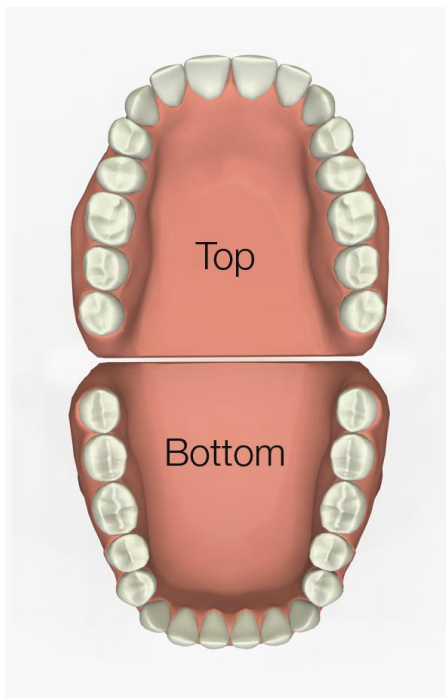
9. Describe the current dental condition of ALL your teeth (front and back). IF POSSIBLE, PLEASE INCLUDE A PHOTO OF YOUR DAMAGED TEETH.

Date of injury: _____ How many teeth are missing? _____

How many teeth are broken or damaged (not missing)? _____

Description of dental injuries: _____

Please mark ALL teeth with an “X” that are in need of any dental treatment



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 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, minister or medical professional (Cannot be a friend or family member).

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.

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

Counselor Advocate Social Worker Therapist Minister Medical Professional

Comments (optional):

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: _____

Service Verification Form

Only fill out this section if you choose to complete the 10 hours of community service (see page 1, number 2 for details). It must be filled out by a supervisor/manager from the non-profit organization(s) at which you choose to perform your volunteer work.

1. Print Supervisor/Manager name: _____
 Non-Profit Agency: _____ Signature: _____
 Date applicant completed volunteer work: _____
 Hours of volunteer work completed: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

2. Print Supervisor/Manager name: _____
 Non-Profit Agency: _____ Signature: _____
 Date applicant completed volunteer work: _____
 Hours of volunteer work completed: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

3. Print Supervisor/Manager name: _____
 Non-Profit Agency: _____ Signature: _____
 Date applicant completed volunteer work: _____
 Hours of volunteer work completed: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

4. Print Supervisor/Manager name: _____
 Non-Profit Agency: _____ Signature: _____
 Date applicant completed volunteer work: _____
 Hours of volunteer work completed: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

Please mail pages 2-7 to: GBAS, 402 West Wilson Street, Madison, WI 53703 Or fax to: 888.488.6888