RESTORE A smile, RESTORE A life.

GIVE BACK A SMILE®
AACD CHARITABLE FOUNDATION INC.

Support The Give Back a Smile program (GBAS) was established by the American Acadamy of Cosmetic Dentistry, Inc. ("AACD") and the AACD Charitable Foundation to connect eligible survivors of domestic and/or sexual violence who've received dental injuries to the smile-zone from the abuse with volunteer cosmetic dentists to restore their smiles at no cost. The dental injuries need to be a direct result of the domestic and/or sexual violence. We have volunteer cosmetic dentists throughout the United States but services are based on volunteer availability in your area at the time you apply. Please be aware that our volunteer pool is more limited if you need dental care beyond the front 8 teeth and implants are not guaranteed.

Give Back a Smile Eligibility Requirements

1. Persons age 18 and above who have received dental injuries to the smile-zone from:
    - Former intimate partner or spouse (husband, wife, domestic partner, boyfriend, or girlfriend)
    - Family member
    - Sexual violence (sexual assault and/or rape)
    - Human trafficking
2. The incident causing the dental injuries generally must have occurred at least one year ago and the applicant must be away from all abusive situations for a minimum of one year. GBAS may make exceptions if the abuser is deceased or incarcerated.
3. All applicants need to meet with a domestic violence/sexual assault advocate, case manager, counselor, therapist or doctor with experience in counseling survivors of domestic violence/sexual assault, at least once and that person needs to complete page 6 of the application.
4. The program does not help with dental neglect (such as cavities), gum disease, jaw injuries, or orthodontic treatment (braces, shifted teeth, and/or spaces between teeth).
5. The program does not replace or fix previous dental work done by any dentist including GBAS volunteers (such as dental work that does not fit, looks bad, no longer works, work that was started but not completed).
6. An application fee of $20 **OR** 10 hours of community service is required to apply. The $20 fee must be paid by money order only. See page 9 for additional information for the community service requirement.

NOTE: Read this entire application carefully before filling it out. It will be returned if all pages are not completed and the application is not signed and dated. All application submission materials MUST be submitted together, including the $20 application fee and support verification form. If you have questions call GBAS at 800.543.9220.

Mail this application to: GBAS, 200 River Place Ste 150, Monona, WI 53716

Fax to: 888.488.6888

Email to: givebackasmile@aacd.com

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Before you return your application, please read the following:

1. Be sure all sections of this application are filled out completely, correctly and legibly. All application submission materials MUST be submitted together. Please do not send the $20.00 application fee or support verification form separately.
2. In order to apply for the GBAS program, you must send in a $20.00 application fee, or complete 10 hours of community service (volunteer work) within 12 months prior to the date of your application. The fee or Community Service Verification Form (page 9) must be included with your application, or it will be returned to you.
3. Please do not include additional documents with your application (i.e. police reports, medical records, etc.). They will not be reviewed and will be shredded to ensure your privacy.
4. Make sure you have met in-person with a counselor, advocate, case manager, therapist, or medical professional described in the Support Verification Form (page 6) at least once and have that person complete and sign that form. If this is not able to be verified your application will be considered incomplete and returned to you for completion.
5. Make a copy of this application for your files.
6. Mail your completed application to GBAS, 200 River Place Ste 150, Monona, WI 53716 or fax to 888.488.6888. *If including a money order, you must MAIL your application.*

What happens after I send in my completed application

1. GBAS reviews applications first. If your application does not qualify for the program, you will be mailed a letter within 45 days.
2. If your application is approved by GBAS, we will begin looking for a volunteer dentist. Please be aware that this process can take months. Once we've determined whether or not there is an available volunteer dentis, you will receive a letter with the next steps.
3. When a volunteer is confirmed, you will be mailed the dentist's information to schedule your consultation, which must be done within 30 days of receiving the letter. After the consultation, the dentist will let you know what they can and cannot do, and whether your dental situation fits within the guidelines of the program. You are not accepted into the program until the dentist sees you for a consultation and determines that they are able to donate the dental work that you need. The program does not guarantee implants or patient requested dental work.
4. Please note: If we do not have an available volunteer located within 200 miles of your location, we unfortunately cannot provide you services and we will inform you of this via mail. Keep in mind that our volunteer pool is more limited if you need dental care beyond the front 8 teeth.
5. All program correspondences will be sent through the mail. If your address changes, please inform the GBAS office right away. If we are unable to contact you, your case can be closed.

FOR OFFICE USE ONLY

Date Received: _____ **Authorization Code:** _____

☐ Money Order Received ☐ Community Service Verification Received

PLEASE PRINT CLEARLY

If your application is not legible or fully completed it will be returned. All questions are required unless indicated as optional.

Personal Information

1. First Name: _____ Middle Initial: ____ Last Name: _____
2. Date of Birth:_____
3. *(Optional)* The gender with which you identify: ☐ Male ☐ Female ☐ Other
4. *(Optional)* What is your race/ethnicity? ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Hispanic or Latino/a ☐ Native American/American Indian ☐ Other_____
5. Mailing Address: *We mainly correspond through mail. Please make sure this is accurate and updated.*

   Street: _____

   City: _____ State: _____Zip Code: _____
6. Phone: _____
7. E-mail Address: _____
8. How did you hear about the program? _____
9. Are you able to travel up to 200 miles? If traveling is necessary, we can help with gas expenses but it's your responsibility to coordinate your transportation.

   ☐ **Yes**

   ☐ **No,** how far can you travel? _____ **miles**

   How will you get to your dental appointments? _____
10. Tell us who damaged your teeth, check ONE of the following:

    ***NOTE: Month and year required**

    ☐ Former intimate partner or spouse (husband, wife, domestic partner, boyfriend, or girlfriend)

    ☐ Family member (not intimate partner or spouse) Relationship: _____

    ☐ From sexual violence (sexual assault and/or rape)

    ☐ Other, please describe: _____

    *The date you left the situation/abuser: **MONTH**:_____**YEAR**:_____

    If it has been LESS than one year but the abuser/perpetrator is deceased or incarcerated:

    Check One: ☐ Deceased

    ☐ Incarcerated, release date **(required)**: _____

11. *(Optional)* If you're comfortable, briefly tell us about your personal story and how domestic/sexual violence has affected you:

Dental Information

1. Briefly describe the specific incident(s) of domestic/sexual violence that caused direct damage to your teeth:

   _____

   _____

   _____

2. Date of the incident: MONTH:_____ YEAR:_____
3. List **ALL** dental issues in your entire mouth, including any issues that were not caused by the violence:

   Please include a photo of your teeth with the application if possible. Your application will still be considered if you cannot send a photo.

   _____

   _____

   _____

4. How many teeth are broken or damaged (not missing) in your entire mouth? _____
5. How many teeth are missing in your entire mouth? _____
6. Have you had dental work done to your damaged teeth (such as bridge or denture, etc.)?

   ☐ **No**
   ☐ **Yes, Date:** _____

   If YES, Explain:_____

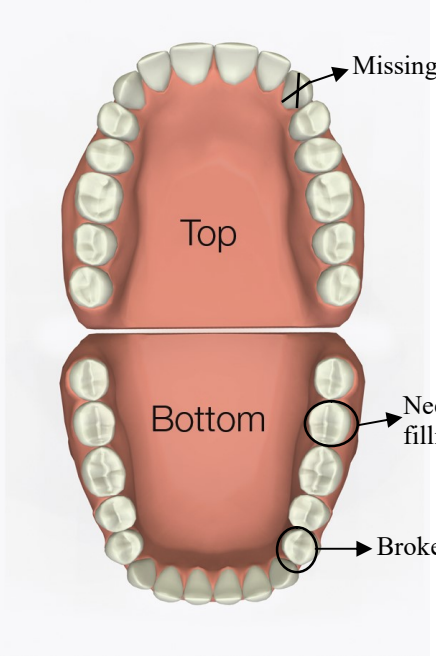
   _____

7. **Please complete the following tooth diagram with ALL of your dental needs, not only the teeth that were damaged from domestic and/or sexual violence.**

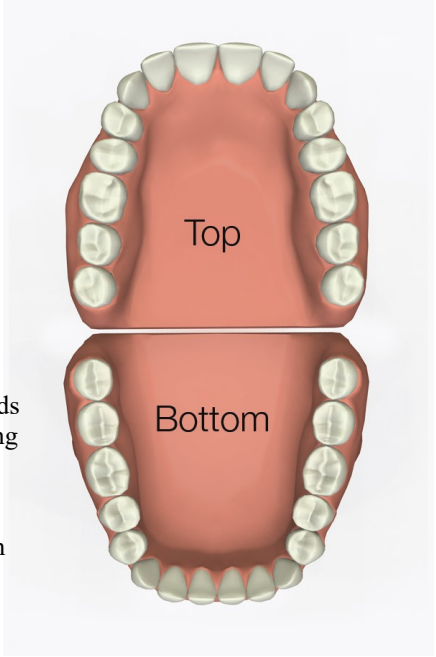
CIRCLE ALL teeth that are in need of any dental work (not missing)

Draw an "X" on ALL teeth that are MISSING

Example Only



Please Complete



Patient Agreement Form

Our goal is for you to be successful in the program. It's important for all approved applicants to be in a place in their lives where they can successfully make it to all scheduled dental appointments. All the dentists volunteer their time, services, and materials. To ensure their time and efforts are given proper respect we do strictly adhere to all of the program policies and expectations.

Please sign your initials next to each statement below and sign at the bottom, letting us know that you understand the application process and GBAS guidelines.

_____ Based on my situation, I verify that I have been away from all abusive situations for at least one year

_____ The dental work I may receive is donated (The dentist does not receive payment)

_____ My $20.00 application fee is **non-refundable.**

_____ Sending in an application to the GBAS program does ***not*** guarantee I will be sent to a dentist or that I will be accepted as a patient.

_____ If there is not an available volunteer dentist located within 200 miles of your location, we unfortunately cannot provide you services. Please be aware that our volunteer pool is more limited if you need dental care beyond the front 8 teeth.

_____ When I receive a letter from the GBAS program informing me of a volunteer dentist who may provide my dental work under the GBAS program, I understand that it is my obligation to schedule the first appointment within 30 days.

_____ The GBAS volunteer dentist makes the final decision of eligibility and disqualification (as described below) per the program guidelines and decides what dental work fits within the program. Dental work is **not guaranteed** and I hereby release and waive any and all claims that I may have against the American Academy of Cosmetic Dentistry, Inc., and/or the American Academy of Cosmetic Dentistry Charitable Foundation that may arise with respect to my participation in the program and/or my dentist-patient relationship with the GBAS volunteer dentist.

_____ The program **does not** help with dental neglect (such as cavities), gum disease, jaw injuries, or orthodontic treatment (braces, shifted teeth, and/or spaces between teeth).

_____ The program does not replace or fix previous dental work (such as dental work that does not fit, looks bad, no longer works, an implant that was started but not completed by any dentist in the past including GBAS volunteers.

_____ The program **does not guarantee specific dental work that I request or want** (such as implants or teeth whitening)**.**

CONTINUED ON NEXT PAGE

_____ Among other reasons, I can be **disqualified** from the GBAS program at any time if I:

- Don't call to schedule my first appointment within 30 days
- Reject the volunteer dentist's proposed treatment plan
- Don't show up to appointment(s)
- Cancel appointment(s)
- Cancel appointment(s) without a 48-hour notice
- Don't stay in contact with the volunteer dentist or the GBAS office
- Disrespect the dental office or GBAS staff
- If the volunteer dentist terminates you as a patient for any reason
- If you provide false information in your application or otherwise fail to comply with the GBAS program

_____ If I am disqualified, my GBAS case will be closed and I will not receive any further dental services under the GBAS program.

_____ I will update the GBAS office of any changes to my phone number or mailing address. If the GBAS office can't find me, my case may be closed, with no further dental services being provided. All changes must be sent directly to the GBAS office. No returned mail will be forwarded.

_____ If I'm eligible for the program, once my GBAS case is done within program guidelines, the dentist will not provide any further dental work to me or keep me as patient.**My GBAS case will not be reopened for any reason.**

_____ Your application will be reviewed as quickly as possible. In order to keep the process moving, we ask that you **please don't call** to check the status of your application. These types of calls will not be returned to you.

I verify that the information I provided on this application is true. I authorize the release of this information to the American Academy of Cosmetic Dentistry, Inc. (AACD), the AACD Charitable Foundation and the GBAS program. I give permission for the GBAS program to verify the information in this application, including to contact the person completing the Support Verification Form and, if I have provided community service as part of my application, the charitable organization(s) identified in the Community Service Verification Form. I also authorize the GBAS program to share information, in my application and about my eligibility, with one or more volunteer dentists in the GBAS program.

I have read the entire Give Back a Smile application, including this Patient Agreement Form, and understand my obligations and the dental services that I may be eligible to receive under the GBAS program.

Signature: _____ Date: _____

Information Release

This section is OPTIONAL and does not affect your eligibility.

We may have opportunities for you to share your story, photos and etc. for the purpose of increasing awareness of domestic violence and Give Back a Smile. If it is safe for you to do so, are you interested in participating?

☐ YES

☐ NO

If YES, please review and complete the following release form:

In consideration of the dental services provided to me under the GBAS program, I consent to the use of the below-initialed items by the American Academy of Cosmetic Dentistry, Inc. (AACD) and the AACD Charitable Foundation, for the purpose of marketing, publicity or advertising of the Give Back a Smile program. Publication may occur in, commercial publications, newspapers, exhibit booths, on internet websites, social media, television, radio and similar means.

I acknowledge that I will receive no further compensation for the use of the below-initialed items. I also agree that neither the Photographer/Owner nor AACD, its Charitable Foundation and the GBAS program can guarantee the quality of the images. I release AACD and its Charitable Foundation from all liability for the below authorized uses unless it can be shown the use or publication is malicious. I waive any right I may have to inspect and/or approve the specific use of the image and/or text that may be associated with it. I have read and had the opportunity to carefully review and ask questions about this release.

I understand that I can revoke this authorization by written notice to the GBAS program. I understand that any such revocation will not be effective for any publication that occurred, or had been scheduled, prior to my revocation being received by the GBAS program.

Please write your initials next to any of the following that you authorize:

I may be contacted to participate in:

_____Television Interviews

_____Radio Interviews

_____Print Interviews

I authorize the use of my:

_____Full Face Photos

_____Teeth Only Photos

_____Written Story/Statements

_____First Name

_____ _____

Applicant's Signature Date

Support Verification Form

Applications will be considered incomplete if this form is not completed and signed by a qualifying professional. This form cannot be completed by a friend, family member, or faith leader.

For some, dental treatment can be a significant time and emotional investment. We recognize that the treatment may be difficult for the patient and want to ensure that they have access to support as needed. It is also important that the applicant has a stable living situation to ensure they will be able to travel to their dentist for the duration of the treatment as their treatment can take years. This form helps us ensure that the criteria needed to be successful in this program are met. Additionally, the goal of this program is to help those who have experienced sexual/domestic violence and we want to ensure that our resources are only going to those who fit that criteria. For more information please contact our Case Manager at **givebackasmile@aacd.com** or 800.543.9220.

1. Please provide your contact information:

   Print Name: _____ Title: _____

   Agency: _____

   Business Email Address: _____

   Business Phone: _____ Business Address: _____

   City: _____ State: _____ Zip Code: _____

   ☐ I would like additional information on this program for my agency

2. Please indicate your role by checking one of the following:

   ☐ Counselor/Therapist ☐ Advocate ☐ Case Manager ☐ Medical Professional

3. Please initial each item below to signify you attest each is true:

   _____I confirm I have met with the applicant in person at least once.

   _____I confirm I have experience and formal training in working with victims of sexual/domestic abuse.

   _____Based on their explanation, I believe the applicant's injuries were caused by domestic/sexual violence.

   _____Based on their explanation, I believe that the applicant has been away from all abusive relationships for at least one year and that the violent incident happened over a year ago, or the abuser is deceased or incarcerated.

   _____I understand that I may be contacted to verify my place of employment, credentials, and signature.

4. Please provide any additional information that would assist us in reviewing this application:

   _____

   _____

   _____

Signature: _____ Date: _____

Community Service Verification Form

This page is only to be completed if you choose to do community service instead of paying the $20 application fee. You must complete a minimum of 10 service hours within the last year to fulfill this requirement. You can volunteer for the charity of your choice (such as a shelter, food pantry, or nursing home), and the volunteer verification form below must be completed. This form must be filled out and signed by a supervisor/manager where you did your volunteer work.

1. Print supervisor/manager name: _____
   Non-profit agency name: _____
   Hours of volunteer work completed: _____
   Date applicant completed volunteer work: _____ Signature: _____
   Phone: _____ Address: _____
   City: _____ State: _____ Zip Code: _____

2. Print supervisor/manager name: _____
   Non-profit agency name: _____
   Hours of volunteer work completed: _____
   Date applicant completed volunteer work: _____ Signature: _____
   Phone: _____ Address: _____
   City: _____ State: _____ Zip Code: _____

3. Print supervisor/manager name: _____
   Non-profit agency name: _____
   Hours of volunteer work completed: _____
   Date applicant completed volunteer work: _____ Signature: _____
   Phone: _____ Address: _____
   City: _____ State: _____ Zip Code: _____

4. Print supervisor/manager name: _____
   Non-profit agency name: _____
   Hours of volunteer work completed: _____
   Date applicant completed volunteer work: _____ Signature: _____
   Phone: _____ Address: _____
   City: _____ State: _____ Zip Code: _____