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 and Canada but services are based on volunteer availability at the time you apply. If we do not have an available volunteer 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 and implants are not guaranteed.

Give Back a Smile Application Information

WHO IS ELIGIBLE:

1. Adult (18+) women and men 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 (may be considered)

Other violent attacks or accidental dental injuries, while traumatic, do not qualify.

2. The incident causing the dental injuries generally must have occurred at least one year ago. GBAS may make exceptions to the one-year requirements if the abuser is deceased or in jail/prison.
    - If hurt by an intimate partner or spouse: you need to be out of all abusive relationships for a minimum of one year.
    - If hurt by a family member: you need to have lived in a separate home from that person for a minimum of one year.
    - If hurt because of sexual assault: it needs to have happened at least one year ago
3. All applicants need to meet with a domestic violence/sexual assault advocate, case manager, counselor, faith leader, 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. In other words, dental work that does not fit, looks bad, no longer works, an implant that was started but not completed.

More application instructions on the back of this page

6. **To apply for the GBAS program, you must do one of the following:**

   - **Include a $20.00 application fee paid by <u>money order ONLY</u>, to the GBAS program. This is nonrefundable.**

   -OR-

   - **Complete 10 hours of community service (volunteer work) before sending in your application**. The community service must have been performed within 12 months prior to the date of your application. You can volunteer for the charity of your choice (such as a shelter, food pantry, or nursing home), and the volunteer verification form (page 9) must be completed.

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. Please do not send the $20 application fee or support verification form separately. If you have questions, call GBAS at 800.543.9220.

Mail this application to: GBAS, 402 West Wilson Street, Madison, WI 53703 or fax to: 888.488.6888

FOR OFFICE USE ONLY

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

☐ Money Order Received ☐ Community Service Verification Received

PLEASE PRINT

1. First Name: _____ Middle Initial: ____ Last Name: _____
2. Date of Birth:_____

*We are often asked about the demographics of those we serve. The following **two questions are optional**, but helpful.*

3. The gender with which you identify: ☐ Male ☐ Female
4. What is your race? ☐ White or Caucasian ☐ Black or African American ☐ Hispanic or Latino ☐ Native American or American Indian ☐ Asian/Pacific Islander ☐ Other
5. Mailing Address:

   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? **Yes** _____ **No**_____ If not, how far can you travel? _____ **miles**. If traveling is necessary, we can help with gas expenses but it's your responsibility to coordinate your transportation.

   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)

*****The date you left the abuser (must be away from all abusive situations):
MONTH:_____**YEAR**:_____

____ Family member (not intimate partner or spouse)

*****If from a family member, **describe relationship**_____

***** The date you last lived with this family member: **MONTH**:_____**YEAR**:_____

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

*****The date of the sexual violence: **MONTH**:_____**YEAR**:_____

___Other (i.e human trafficking) please describe_____

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

If it has not been at least one year but the abuser/perpetrator is deceased or in jail/prison, check one: ____Deceased ____In jail/prison, release date (**required**): _____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

12. Tell us specifically how your teeth were damaged as a direct result of domestic or sexual violence:

_____
_____
_____

13. Describe all of your dental needs (List **ALL** dental issues in your entire mouth, not just from the violence) PLEASE INCLUDE A PHOTO OF YOUR TEETH WITH THE APPLICATION IF POSSIBLE

_____
_____
_____

14. Date of incident: _____ How many teeth are missing in your entire mouth? _____
    How many teeth are broken or damaged (not missing) in your entire mouth? _____

15. Have you had dental work done to your damaged teeth (such as bridge or denture, etc.)?
    Yes_____ **No**_____ **If YES**, Date: _____

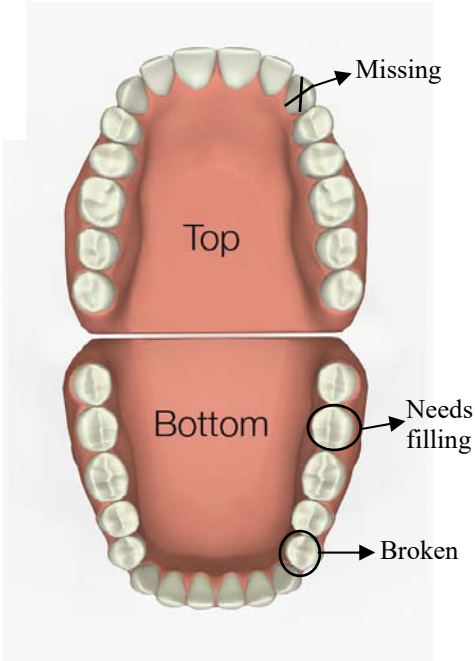
    If YES, Explain:_____
    _____

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.

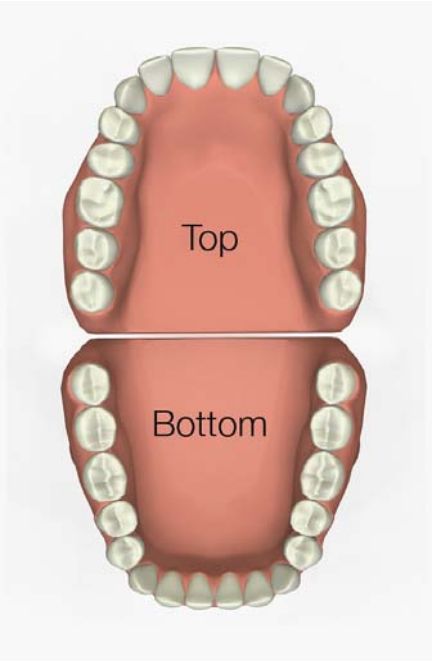
16. **Draw an "X" on ALL teeth that are MISSING**

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

Example Only



Please Complete



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.

Signature: _____ Date: _____

Patient Agreement Form

Please write 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)**.**

_____ 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 appointments
- Cancel appointments
- Cancel appointments 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 a 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 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

Support Verification Form

This application will be returned to the Give Back a Smile applicant if this form is not completed and signed by one of the professionals described in the following paragraph.

All applicants for the Give Back a Smile (GBAS) program must see **in-person,** at least once before the application is completed**, a counselor, advocate, case manager, therapist, faith leader or medical professional with prior training or experience in counseling survivors of domestic violence/sexual assault.** There are two reasons for this requirement:

- To connect the applicant with support systems within their community.
- To have an independent source confirm after having heard the applicant's story, they affirm the applicant received their dental injuries from domestic or sexual violence, and the applicant is now away from all abusive situations for a minimum of one year.

The applicant may either see someone they have worked with in the past that is willing to reconnect with the applicant for the purposes of this application or seek a referral to a local domestic violence program by calling the National Domestic Violence Hotline at 800.799.7233.

This form **cannot** be completed by a friend or family member.

If the person completing this form needs more information about the GBAS program, contact the Foundation Case Manager at **givebackasmile@aacd.com** or 800.543.9220.

Please indicate your role by circling one of the following:

Counselor Advocate Case Manager Therapist Faith Leader Medical Professional

Please provide information that would assist us in reviewing this application and describe your training and prior experience in counseling victims of domestic violence/sexual assault:

_____

_____

_____

_____

_____

_____

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 domestic or sexual violence. Based on his/her explanation, I also believe: (a) that she/he has been out of all abusive relationships for at least one year or, in the case of sexual violence, that the sexual violence happened at least one year ago; or (b) the abuser is deceased or is in jail/prison. I understand that I may be contacted to verify my place of employment, credentials and signature.

Signature: _____ Date: _____

Print Name: _____ Agency: _____

E-mail Address: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Would you like us to send program literature for your agency? ____Yes ____No

<u>This section is *OPTIONAL* and does not affect your eligibility</u>

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_____

I authorize the use of my name:

Yes_____ No_____

_____ _____

Applicant's Signature Date

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 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, faith leader or medical professional described in the Support Verification Form on page 6 at least once and have that person complete and sign that form.
5. Make a copy of this application for your files.
6. Mail your completed application to GBAS, 402 West Wilson Street, Madison, WI 53703 or fax to 888.488.6888. Note: if including a money order, DO NOT fax your application.

What happens after I send in my completed application

- GBAS reviews applications first. If your application does not qualify for the program, you will be mailed a letter within 45 days.

- If your application is approved by GBAS, we will begin looking for a volunteer dentist (remember that the dentist has final approval). Please be aware that this process will take time (potentially several months). Once we've determined whether or not there is an available volunteer dentist in your location, you will receive a letter indicating the status of your case.

- When a volunteer is confirmed, you will be notified of the volunteer dentist. After your first appointment which you must schedule within 30 days of receiving that notice, he/she will let you know what they can do, what they can't do, or 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 he/she is able to donate the dental work that you need. The program does not guarantee implants or patient requested dental work. Note: you may be disqualified from the program at any time.
- 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.
- 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.

Community Service Verification Form

This form is to be completed only if you chose to do 10 hours of community service. ***It 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: _____