smile OREGON

7327 SW Barnes Rd. #219
Portland, Oregon 97225

www.SmileOregon.org
info@smileoregon.org

Grant Application - Getting Started:

Forms completed by the Patient, Parent, or the Legal Guardian.

Attach photocopies of the most current IRS form 1040EZ, 1040A, or 1040 (Please, include all responsible parties.)

Provide the patient's health care provider with the appropriate attached letter.

Provide the patient's craniofacial team with the appropriate attached letter.

Patient Photograph

Grant Application - Criteria:

In evaluating applications, Smile Oregon will consider applications based on the following criteria:

1. The individual receiving care must be 21 years old or younger.
2. Smile Oregon gives priority to patients living in Oregon.
3. The patient must be able to demonstrate a clinical and financial need.
4. In order to be a sustainable organization every patient applicant will be asked to contribute resources based on their financial situation.

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Patient Information:

1. Patient's name

   First:______________________________ Last:______________________________

2. Patient's birth date:__________
   (MM/DD/YYYY)

3. Is the patient a (please select one): MALE FEMALE

4. Parent/Legal guardian name:

   First:______________________________ Last:______________________________

5. Relationship: (please select one)

   Mother Father Legal Guardian Self Other__________________

6. Parent/Legal guardian name:

   First:______________________________ Last:______________________________

7. Relationship: (please select one)

   Mother Father Legal Guardian Self Other__________________

8. Primary contact phone number: ______________________________ example (XXX) XXX-XXXX

9. Secondary contact phone number: ______________________________ example (XXX) XXX-XXXX

10. Mailing address:

    Street address, P.O. Box, c/o: ______________________________

    Apartment, suite, unit, building, floor, etc.: ______________________________

    City, State, Zip Code: ______________________________

11. Email address:______________________________

    (You must enter a valid email address - we will be communicating with you via email. If you do not have an email address, please sign up for a free account with Yahoo, Hotmail, Gmail, etc.)

12. Is this the first time you have submitted an application for a Smile Oregon grant?

    (please select one) YES NO (If no, please explain)

13. Name of patient's health benefit plan (health insurance provider, etc.)

    ____

14. Person who carries this health benefit plan:

    First:______________________________ Last:______________________________

15. What is the relationship of the person who carries the health benefit plan for the patient?

    ____

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16. Does the patient have a secondary health benefit plan?

    (please select one) YES NO

17. Name of patient's second health benefit plan (health insurance provider, etc.)

    ____

18. Person who carries this health benefit plan:

    First:______________________ Last:______________________

19. What is the relationship of the person who carries the health benefit plan for the patient?

    ____

20. Enter a brief description of the medical history of the patient.

    (This section is for the patient to complete, NOT THE PROVIDER)

21. Please describe what the Smile Oregon grant will be used for:

    [please give all relevant details. (i.e.. cost(s), timelines, dates, etc.)]

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22. Does the patient's health benefit plan cover some of the cost?

    (please explain)

23. Does the patient's secondary health benefit plan provide financial assistance for this item?

    (please explain)

24. Does the patient receive any assistance for this medical item from the public school or private school where he/she attends?

    (i.e. the school provides speech therapy)

    (please select one) YES (If yes, please explain) NO

25. Has the patient sought assistance to help with the medical item(s)/service(s) you are requesting from other public or private sources? For example, city, county, state organizations and/or other charities?

    (please explain)

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26. Would your out of pocket cost, after insurance, be best categorized as one-time only cost or recurring cost?

    (please select one) One-time only Recurring cost Both

27. Based on your choice above (one-time or recurring cost), what is your estimated out of pocket cost, after insurance, in whole dollars? If recurring please put the recurring payment amount, not the total amount and the number of payments.

    $_________________ ___________ payments

28. How did you hear about Smile Oregon?

Financial Statement: (All inputs on this page are whole dollars only. Please round to the nearest dollar.)

29. Number of people living in household:________

Assets (for household):

30. Cash (checking, savings, safe deposit box, mattress): $____________________
31. Investments [401(k), IRA's, Other]: $____________________

Monthly Income	**$**
Monthly Gross Pay	
Monthly Child Support Income	
Monthly SSI, TANF, Food Stamps, etc.	
Monthly Other	

32. Additional financial comments (if any):

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Notice of Privacy Policy:
We value you as an applicant and we know how much privacy means to you. You will have the opportunity to review our policies for collecting, using, securing and sharing information the first time we do business with you and every year you are a Smile Oregon applicant.

Our Privacy Principles:
- We do not sell applicant information.
- We do not allow those who are doing business on our behalf to use your application information for their own marketing purposes.
- We require any person or organization providing products or services on our behalf to protect Smile Oregon applicants' information.
- We do not share applicant information with anyone unless:
  - You expressly authorize it; or
  - It is permitted or required by law; or
  - Your application with us permits us to do so.
- We afford our prospective and former applicants the same protections as existing applicants with respect to the use of personal information.

Information We May Collect:
We collect, use and share information we need to conduct our business, to advise you of our products and services, and to provide you with customer service. We may collect and maintain several types of applicant information needed for these purposes, such as those below.

Types of information we may collect and how we gather it:
- From you; on applications, other forms, in-person, telephone, contacts.
- From your transactions or experiences with us.

How We Use Information About You:
We use applicant information, including consumer report information (if provided), to grant and/or communicate Smile Oregon products or services, process your application, ensure proper billing, service your application, enhance your customer service experience, and offer you other products or services that may suit your needs.

Information Disclosure:
We share information about our transaction and experiences with you within Smile Oregon to better serve you and to help meet your current product and service needs. We may share information about you with persons or organizations inside or outside Smile Oregon for our everyday business purposes and as permitted or required by law. We also may share information about you with companies that perform marketing or other services for us.
We may also share information with other entities as needed to handle your application and to protect against fraud and unauthorized transactions. For example, we might share name, address and coverage information with a provider to speed up services or appointment scheduling.

Smile Oregon Protects Applicant Information:
The privacy of our applicants has always been important to Smile Oregon. We maintain physical, eletronic, and procedural safeguards that comply with federal and state regulations to guard nonpublic personal information. In addition, we regularly review our policies and practices, monitor our computer systems, and test the strength of our security. Taking these steps helps us to ensure the safety of our applicants' information.

Other Important Information:
Information for Internet, Mobile, and Social Media Users:
Smile Oregon uses internet cookies, analytical tools, and other technologies to customize our website, online presences, mobile applications, and social media interactions to enhance your overall customer experience.

Acknowledgments/Wavier:
By submitting this application, Applicant agrees to the following terms and conditions:
- Applicant shall submit 6 to 12 month progress reports to Smile Oregon.
- Applicant shall cooperate with proposed treatment plan; including, but not limited to, being on time for appointments, avoiding no-shows, maintaining good overall health and follow physician recommendations.
- Applicant shall sign all necessary documents to allow Smile Oregon to comply with HIPAA laws.
- Applicant understands and acknowledges that Smile Oregon does not guarantee approval of application.
- Smile Oregon reserves the right to change the terms and conditions of all Smile Oregon grants at anytime without notice.
- Smile Oregon will make every effort to respond to Applicant's application within sixty (60) days from date of receipt of Applicant's application with forward procedures.
- Applicant agrees to sign all necessary releases of information, including, but not limited to, releases of medical information, photography and publicity releases.

After all documents are completed, you have read the Acknowledgements/Wavier and signed below, then submit:

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Patient Application

IRS document(s)

Health Care Provider Form

Craniofacial Team Form

HIPAA Form

Patient Photograph

By mail to:

Smile Oregon

7327 S.W. Barnes Rd. #219

Portland, Oregon 97225

Smile Oregon will then provide you with an email confirmation upon receipt of your application.

NOTE: BE SURE TO KEEP A COPY FOR YOUR RECORDS FOR REFERENCE.

Incomplete application will not be considered.

Applicant's Statement:

As the applicant of a Smile Oregon grant I am agreeing to the Acknowledgements/Waiver related to Smile Oregon policies, and state that information contained within the application is, to the best of my knowledge, true and accurate.

33. Signature____ Date:_________________________

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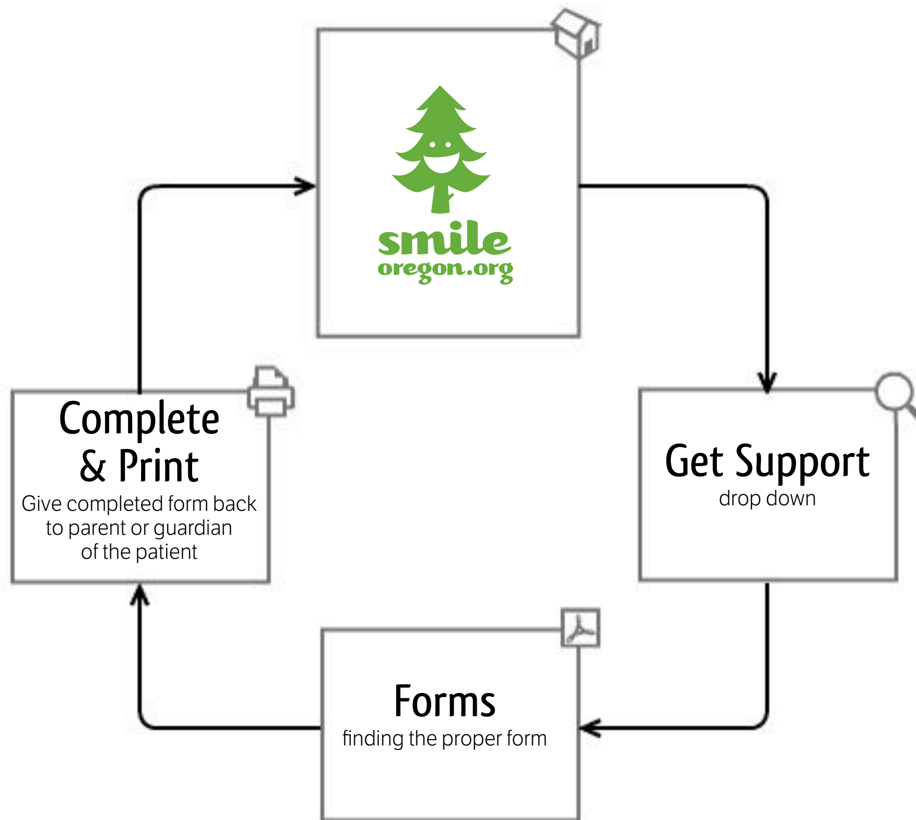
Dear Health Care Provider,

Smile Oregon is a 501c3 non-profit corporation whose mission is to make it possible for every child with a cleft or craniofacial condition living in Oregon to obtain the coordinated care they deserve regardless of their ability to pay. At the same time, Smile Oregon will serve as a centralized source of support and information for patients and families affected by cleft and craniofacial conditions.

To facilitate your patient's application please go to SmileOregon.org. Download, complete, and then print the Health Care Provider Form (see site map below). Please give completed form to your patient, who will then submit to Smile Oregon.

If you have any questions, please contact Smile Oregon via email at Info@SmileOregon.org.

THE COMPLETED HEALTH CARE PROVIDER FORM SHOULD BE RETURNED TO THE PATIENT, PARENT, OR THE LEGAL GUARDIAN WHO WILL SEND IT, ALONG WITH HIS/HER COMPLETED APPLICATION PACKET, TO SMILE OREGON.



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Dear Craniofacial Team,

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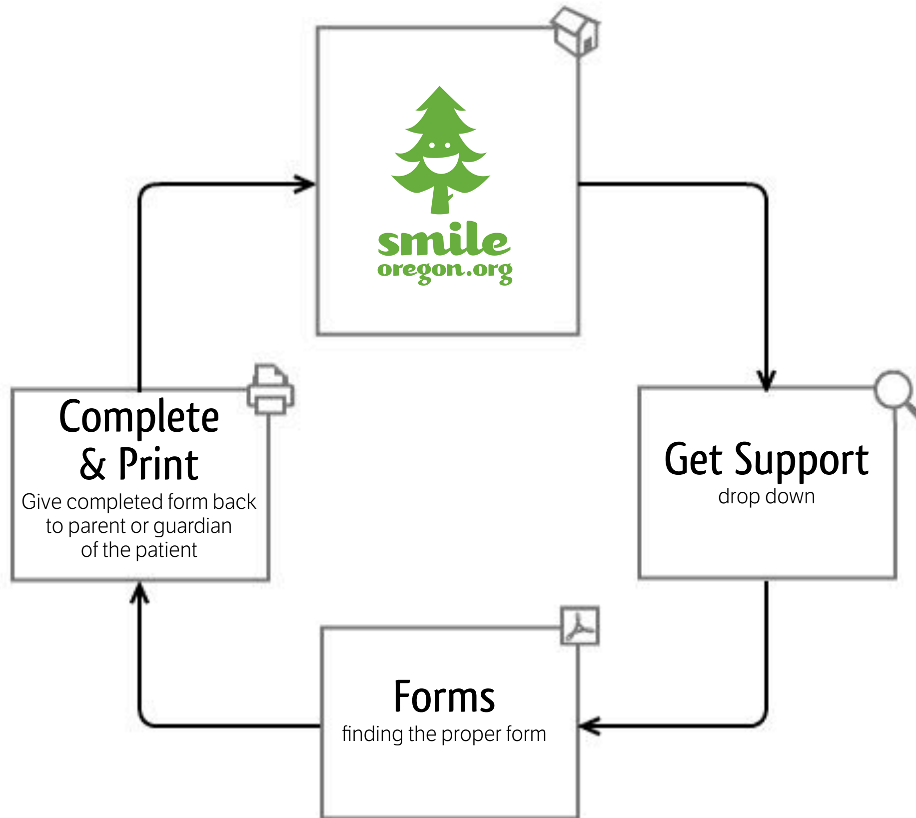
To facilitate your patient's application please go to SmileOregon.org. Download, complete, and then print the Craniofacial Team Form (see site map below). Please give completed form to your patient, who will then submit to Smile Oregon.

If you have any questions, please contact Smile Oregon via email at Info@SmileOregon.org.

THE COMPLETED CRANIOFACIAL TEAM FORM SHOULD BE RETURNED TO THE PATIENT, PARENT, OR THE LEGAL GUARDIAN WHO WILL SEND IT, ALONG WITH HIS/HER COMPLETED APPLICATION PACKET, TO SMILE OREGON.



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