Guidelines in applying for braces through the Smile for a Lifetime Foundation:

- **Two letters of recommendation** are mandatory. Please do not submit more than two letters, and limit each recommendation letter to one page each. Please type or print clearly with black ink (no pencil). Letters of recommendation must be *written by professionals* – teachers, coaches, dentists, counselors, pastors, etc.

- A clear **5x7 head-shot photo with full smile & teeth showing must be included** with application.

- The General Dentist Form must be completed by the applicant’s general dentist and/or hygienist and submitted with the application.

- The application, letters of reference and photos will **not** be returned and will become property of Smile for a Lifetime Foundation.

- Applicant must be a resident of the Northwest Arkansas area.

- Applicant must have a positive attitude.

- Applicant must agree to follow the treatment plan and demonstrate the ability and commitment to keep and make all appointments on time.

- Applications will be reviewed on a quarterly basis. Our quarters are: **Jan 1-March 31, April 1-June 30, July 1-Sept 30, and Oct 1-Dec 31**

- Each applicant will be notified of approval or denial after the end of each quarter.

Return the completed application, General dentist form, letters of recommendation and photo together in **one packet** to:

Smile for a Lifetime Foundation  
PO Box 858  
Bentonville, AR 72712

**Questions:**  
s4l.nwa@gmail.com

**Applications that do not meet these criteria will be considered incomplete and will NOT be voted on by our Board of Directors.**

**Let it be noted that while Dr. Jeremy Smith, Dr. Darrin Storms, and Dr. Boyd Whitlock have agreed to be orthodontic providers for this foundation, they do not serve on the Board of Directors (they do not personally choose the recipient of the orthodontic scholarship).**
A completed General Dentist Form

A 5x7 head shot photo of applicant with full smile and teeth showing.

Two letters of recommendation – typed and limited to one page each. Letters of recommendation must be written by professionals – teachers, coaches, dentists, counselors, pastors, etc.

Applicant Questionnaire

*Application must be complete and not missing any information to be considered
**All applications, pictures and supporting documents will NOT be returned and become property of Smile for a Lifetime foundation

Applicant Information:

Name:_____________________________ Birthdate:___/___/____ Age:_________ Sex:_________ Grade:_________

# of times applicant applied to Smile for a Lifetime:_______ Does applicant qualify for ARKids A?_____________

Is applicant covered by dental insurance? (specify company and id#) _____________________________________________

Has applicant ever been evaluated or treated by an orthodontist?______ Orthodontist Name:_____________________

Parent(s)/Guardian Information:

Name:__________________________________________________________

Address:________________________________________________________________________________________

E-mail Address:_____________________________________________________

Phone Numbers: Home:_________________________ Cell:_________________________

Annual household income:_______________ # of household members:_____________

Employer(s): 1)_________________________ 2)___________________________________________

Submitted by (circle one): Self Parent School Counselor Dentist Other_____________

Please explain why this applicant is deserving of orthodontic care through the Smile for a Lifetime program. If applicant is applying on behalf of his/herself, please describe what it would mean to you if you received orthodontic treatment through Smile for a Lifetime. (May attach one additional page if needed)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________
Applicant Questionnaire:

Tell us about yourself. What are your interest and hobbies? What extracurricular activities are you involved with? Do you participate in any community service or volunteer projects? What are your goals for your future?

Why do you want braces? How do you feel about your smile now? How do you think braces could improve your life now and in the future?

If you had a chance to help others, would you? If so, list ways you’d like to assist others.
GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

Date: ______/_____/_____

Applicant's Name: _____________________________________________________________

Applicant's Birthdate: ______/_____/_____

General Dentist: _____________________________________________________________

Office Phone: (_____)______-_______

# of remaining primary teeth: ______

Dental conditions that could be improved with orthodontic treatment:__________________________________________________________

__________________________________________________________

Date of last dental cleaning & exam: ______/_____/_____

Please check one:

___ Patient has received a cleaning and is cavity free.

___ Patient has received a cleaning and completed all restorative treatment.

___ No additional treatments are necessary.

___ Patient has received a cleaning & restorative treatment has been scheduled.

List restorative treatment needed & scheduled dates treatment is to be completed:

__________________________________________________________

__________________________________________________________

__________________________________________________________

___________________________________________

Signature of Dentist/Hygienist

___________________________________________

Printed name of Dentist/Hygienist