Sunshyne Smiles Program
Orthodontic Assistance Application
(to be completed by parent/guardian)

Child's Name: _____ ____ _____
(First) (MI) (Last)

Birthdate: _____ Sex: ____ Male ____ Female

Parent/Guardian Name (s): _____ ____ _____
(First) (MI) (Last)

_____ ____ _____
(First) (MI) (Last)

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

E-mail Address: _____

Number of members in your household Adults: _____ Children: _____

Are Parents/Guardians employed? Father Yes/No
Mother Yes/No

Total Monthly Net Income $_____

Total Monthly Expenses $_____

Yearly family income for past two years Year: _____ $_____ Copy ☐
(Please attach copies of IRS Form 1040)
Year: _____ $_____ Copy ☐

Does your child/family receive SNAP benefits? Yes No

Does your child/family receive free or reduced school lunch? Yes No

Does your family receive housing assistance? Yes No

List amount of liabilities:		List value of assets:	
Mortgage	$_____	House	$_____
Loans	$_____	Investments	$_____
Credit cards	$_____	Land/Real estate	$_____
Other debt	$_____	Savings	$_____
		Other	$_____

Describe any extra ordinary circumstances affecting your child or your family:

_____

_____

_____

Sunshyne Smiles Program
Orthodontic Assistance Application continued

I will make monthly payments to assist with the cost of your child's orthodontic care (total cost will either be $1,000 or $2,000, depending on your income). _____ (initial)

Will your family commit to bringing your child to regular orthodontic visits, at the same location, for two to three years? Yes_____ No _____

Do you agree to have your child's dental records available for review by the Sunshyne Smiles Program? Yes_____ No_____

Do you consent to your child being examined by an orthodontist prior to beginning treatment? Yes_____ No_____

Is the child covered by dental insurance? Yes_____ No _____

If yes, is there an orthodontic benefit: Yes_____ No_____

If yes, give name of carrier:_____

Is the child enrolled in Medicaid? Yes_____ No_____

(Children who qualify for orthodontic care through the Medicaid dental program are not eligible for the Sunshyne Smiles Program. Parents or guardians of children on Medicaid should have their child evaluated and scored through the Medicaid system to determine if their child qualifies for orthodontic treatment. If your child does not meet the criteria to receive funding through Medicaid, a copy of the denial letter from Medicaid will be required in applying for the Sunshyne Smiles Program. Any questions regarding Medicaid orthodontic benefits, please call 1-877-841-1478, ask for the Medicaid Referral Office.)

Present dentist:_____

Address:_____ Office Phone:_____

City/State/Zip:_____

Number of years child has been under the care of this dentist:____

If your child has been with your present dentist less than two years, please provide the names and phone numbers of any former dentists.

Name: _____ Phone:_____

Name:_____ Phone:_____

If your child has already had a consultation with an orthodontist, please provide the name of the orthodontist:

Name: _____

_____
Parent/Guardian Signature

Return application to:
Sunshyne Smiles Program
PO Box 7018
Pierre, SD 57501
Fax: 605-224-9168
amy@sddental.org

Sunshyne Smiles
Orthodontic Assistance Program
Dental Referral Form

Date:_____

Patient's Name:_____ _____ _____ _____
(First) (MI) (Last) (Age)

Referring Dentists Name:_____ _____
(First) (Last)

Dentist's Address:_____ _____ _____ _____
(Street) (City) (State) (Zip)

Dentist's Telephone Number: __(_____)_____

Please note: Applicants who are on Medicaid must first be scored to see if they are eligible for Medicaid orthodontic benefit. For information on scoring, please contact Delta Dental of SD at 1-877-841-1478.

Reason for the referral:

_____

_____

Assessment:

Malocclusion:	**Class I**		**Class II**		**Class III**	
Crowding:	**Mild**		**Moderate**		**Severe**	
Spacing:	**Mild**		**Moderate**		**Severe**	
Overjet:	**Mild**		**Moderate**		**Severe**	
Overbite:	**Mild**		**Moderate**		**Severe**	
Crossbite:	**Anterior**		**Posterior**		**Severe**	
Good oral hygiene: **Yes No**		**Caries free:** **Yes No**		**Physically capable of cleaning teeth: Yes No**		
Positive attitude towards dental care: Yes No		**Ability to complete treatment:** **Yes No**		**Keeps scheduled appointments:** **Yes No**		
Impacted Teeth: **Yes No**		**Missing Teeth:** **Yes No**		**Length of time patient has received care in your office?**		

Please send this form directly to:
South Dakota Dental Foundation
PO Box 7018
Pierre SD 57501
Fax: 605-224-9168
amy@sddental.org

_____
(Referring Dentist Signature)

Sunshyne Smiles Program
Orthodontic Assistance Application
(to be completed by child)

Name: _____

My Parents/Guardian: _____

I live at: _____

_____

I go to school at: _____

My Siblings and their ages: _____ _____

_____ _____

_____ _____

My dentist's name: _____

I would like to have orthodontics/braces because: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Sincerely,

Name: _____

Sunshyne Smiles
Authorization of Release of Protected Health Information

By signing this document, you are allowing the South Dakota Dental Foundation staff to give or receive your child's health care records to other health care providers in order to provide the best care for your child. The records may be sent to a dentist, orthodontists, or other dental specialist.

Patient's Name _____

I hereby authorize:

Sunshyne Smiles Program
C/O South Dakota Dental Foundation
PO Box 7018, Pierre, SD 57501, 605-609-1154

to receive from, or release to, the appropriate health care provider, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian _____
(please print)

Parent/legal guardian signature

_____ Date _____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____ _____

_____ _____

Note: This authorization is valid for four years from date of signature unless revoked in writing prior to that date.

Photo Consent and Release

I consent to the use of pictures of myself, or my child, for program promotion, including print, video and web promotion, events and activities. I also agree that any written information or other material provided by me or my child in connection with the Sunshyne Smiles program may be used in promotional materials, events and activities.

Name of parent/legal guardian _____
(please print)

Parent/legal guardian signature

_____ Date _____