Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

APPLICATION CHECKLIST

☐	Application – completed, as directed in **black ink**	☐	Dental Referral Form
☐	Contract – Read and signed by both parent(s) and applicant	☐	Plan to "Pay It Forward"
☐	Applicant Questionnaire – handwritten by the applicant	☐	Report Card From School
☐	Household Information – complete and accurate	☐	Parent/Advocate Letter of Commitment
☐	2 Letters Of Recommendation – Letters from at least two community leaders or teachers, with contact information attached		
☐	2 Photos – Close up photos of applicant's teeth while smiling. (1) photo, teeth showing from the front and (1) photo of the teeth from the side.		

IT IS YOUR RESPONSIBILITY TO ENSURE ALL DOCUMENTS ARE INCLUDED. WE WILL NOT NOTIFY YOU IF YOUR PACKET IS INCOMPLETE!

ORTHODONTIC SCHOLARSHIP

Smile for a Lifetime is an international program that provides orthodontic scholarships (free braces) to children ages 10-18 years old who normally would not be able to afford treatment. Dr. Mark Paciorek, D.D.S., M.S., P.C. has formed a local chapter to serve a minimum of 6 cases per year in the Central New York area. There is no cost to those chosen to receive an S4L orthodontic scholarship. Scholars will be asked to commit a minimum of 10 hours to community service during the course of their treatment. Scholars are chosen by a local board of directors and the process is competitive. **Scholarships are limited** and based on a complete and accurate application.

QUALIFICATIONS

- Applicant must reside in the Central New York Area
- Family income of no more than (185%) of the federal poverty level. (Income eligibility form attached)*exceptions made on a case by case basis.

  If Chosen, proof of income will be **required** to verify eligibility prior to treatment. W-2, Income tax return, SSI award letter, TANF grant letter etc.
- Applicant must be between the ages of 10-18) * Exceptions will be made on a case by case basis.
- Have "good" dental hygiene practices.
- Must have a functional and/or aesthetic need for braces.
- Must currently be enrolled in school.
- Must demonstrate a positive attitude.
- Must follow and abide by treatment plan set forth by the orthodontist and contract attached.
- Should demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service.
- Must have positive letters of recommendation from at least two community leaders and/or teachers.

*** Chapter may consider exceptions under the "special circumstances" clause. Please speak with an S4L representative for more information**

NOTE: If awarded, Proof of income is required prior to treatment. I.e. W-2, Income Tax Return for previous year, SSI Award Letter, Child Support, TANF grant letter, etc.

APPROVAL PROCESS

- Dr. Mark Paciorek, D.D.S., M.S., P.C, will select 6 applicants yearly and applications will be reviewed in April, August and December.
- Selection is based on the information provided within this packet (i.e. Commentary, personal essay, character, and accompanying letters of recommendation), orthodontic and financial need.
- Please ensure that the packet is filled out completely and accurately. Incomplete packets will not be submitted to review board for selection process.
- If you would like to reapply, please speak with an S4L representative for further information.

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

ORTHODONTIC SCHOLARSHIP APPLICATION FORM

Today's Date:	Primary Dentist:

APPLICANT INFORMATION

Applicant's Last Name:		First:		Middle:

Applicant's Date Of Birth (MM/DD/YYYY):		Applicant's Age:		Applicant's Gender:	MALE	FEMALE

Are you currently enrolled in school:	YES	NO	What grade are you in :		What is your GPA:	

Name of School:	Address (City, State, Zip Code):	Phone Number:	( )
		Fax:	( )

Are you wearing braces?	If you are over the age of 16, what are your plans over the next 3 years (Moving, College, etc.):

Home Address:	City:	State:	Zip:	Home phone no.:	Cell phone no.:
				( )	( )

TO BE COMPLETED BY THE APPLICANT ONLY

How did you hear about Smile for a Lifetime (please circle or write in your answer)?

Internet Search	Family	Friend	Dentist/Orthodontist	Boys & Girls Club	State Office	Other: (Please Specify)
Television	Magazine	Radio	Newspaper	CASA	Internet Ad	

Are you a member of the Boys & Girls Club of America?	YES	NO	Do you have a CASA representative?	YES	NO

There are many reasons why people get braces; please select the following that apply or feel free to add your own:

	Discomfort while eating/drinking		Jaw and/or mouth pain		I look down when talking
	Speech Impediment		I get teased about my teeth		I cover my mouth when I laugh
	It's hard to clean my teeth well		I'm embarrassed to smile		I have a hard time sleeping/Sleep apnea

GUARDIAN INFORMATION

Guardian's Name:	Guardian's Occupation:	Guardian's Employer:	Employer phone no.:
			( )
Guardian's Name:	Guardian's Occupation:	Guardian's Employer:	Employer phone no.:
			( )

Have any other children in the household been treated through Smile for A Lifetime (If so, whom)?

What is the best way to reach you:		Phone: ( )		Email:

***** It is important to understand that orthodontic treatment can span over several years, make your child's treatment a priority*****

What is your primary means of getting to their appointments on time? Also, what is your back up plan for transportation (Bus, Friends or Family, Taxi)?

Are there plans of relocating the family in the next two years? If so, where?

What is most important to you about your son/daughter receiving this scholarship?

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

Attention Non-Parental Guardians:

In order to be considered, you MUST attach copy of medical authorization. If the applicant is in state custody, submit a copy of medical card and consent form.

APPLICANT QUESTIONNAIRE

HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.*

Tell us about yourself. What do you like to do? Favorite hobbies, extracurricular activities, and the types of goals and aspirations in life. Etc.

Tell us about your family. How many siblings do you have, who are they, do they live with you, what do you like to do together? Etc.

Please tell us, in detail, why you would like braces and/or orthodontic treatment and how will it change your life? Etc.

***If the minimum requirements are not met, your application will be considered incomplete and not included in selection process.**

INCOME ELIGIBILTY GUIDELINES

Smile FOR A Lifetime
THE GIFT OF SMILES

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

Household Size	Federal Poverty Level	S4L Maximum Annual Income (185% of Poverty Level)	Weekly Gross Income	Monthly Gross Income	Twice Per Month Gross	Every Two Weeks Gross
1	$11,170	$20,665	$398	$1,723	$862	$795
2	$15,130	$27,991	$539	$2,333	$1,167	$1,077
3	$19,090	$36,317	$680	$2,944	$1,472	$1,359
4	$23,050	$42,643	$821	$3,554	$1,777	$1,641
5	$27,010	$49,969	$961	$4,165	$2,083	$1,922
6	$31,930	$57,295	$1,102	$4,775	$2,388	$2,204
7	$34,930	$64,621	$1,243	$5,386	$2,693	$2,486
8	$ 38,890	$71,947	$1,384	$5,996	$2,996	$2,768

Updates to federal poverty guidelines can be found at http://www.fns.usda.gov/cnd/governance/notices/iegs/iegs.htm

HOUSEHOLD INFORMATION

How many people are in your household?	TOTAL:		Number of Adults:		Number of children:	
Is anyone in the household employed?	Yes	No	**If yes, list below**			

PRIMARY SOURCES OF INCOME

Name:		**Name:**	
Employer Name:		Employer Name:	
Hourly wage/Salary:		Hourly wage/Salary:	
Hours worked per week:		Hours worked per week:	
Gross Income per month:		Gross Income per month:	

OTHER SOURCES OF INCOME

Is anyone receiving or going to receive the following:

Lump Sum Payment (Lawsuit/insurance, settlement, social security, SSI, SSDI, Inheritance, lottery, other)?	Yes	No	Amount:		Frequency:	
Child Support or Alimony (please circle)	Yes	No	Amount:		Frequency:	
Unemployment	Yes	No	Amount:		Frequency:	

ARE YOU CURRENTLY RECEIVING ANY OF THE FOLLOWING BENEFITS?

Type of Benefit	Receiving		Amount	Type of Benefit	Receiving	
Food Stamps	Yes	No		School Lunch Program	Yes	No
WIC	Yes	No		State Provided Childcare	Yes	No
TANF	Yes	No		State Provided Healthcare/Dental	Yes	No

EXPENSES

Please do not include living expenses, i.e. car insurance, utilities, groceries etc…

Do you pay for Adult daycare, child support, alimony, child daycare or medical expenses?	Yes	No	**If yes, list below.**

TYPE OF EXPENSE	WHO IS IT FOR	FREQUENCY (Weekly, Monthly, Annually, Semi-Annually)	AMOUNT If selected, you may be asked to submit proof
RENT / MORGAGE			

CONTRACT

If selected from the pool of applicants by the board members of Smile for a Lifetime Foundation and by Dr. Mark Paciorek

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

to receive orthodontic treatment there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance, if requested, but the decision is largely subjective and based on the completeness of the application, commentary, personal essay, character and the accompanying letters of recommendation submitted with your packet. Orthodontic treatment for the Smile for a Lifetime Foundation of Central New York will be provided by certified orthodontist, Dr. Mark Paciorek.

By submitting and signing this application you understand and agree to the following:

1) I agree that appointments will be at the discretion of Dr. Mark Paciorek DDS, MS, PC

2) I understand that this can mean scheduling appointments during non-peak hours i.e. midafternoon Monday through Thursday.

3) I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result.

4) I also understand that keeping appointments is essential to treatment success and is a requirement of accepting care from Dr. Mark Paciorek

5) If you must reschedule appointments, give the office at least 24 hours' notice. If more than two appointments are missed or appointments are constantly rescheduled it will be considered out of compliance which is grounds for removal of braces and revocation of scholarship.

6) If you *must* relocate prior to the conclusion of treatment, Smile for a Lifetime will do its best to find another service provider. However, it is not guaranteed that Smile for a Lifetime will have another provider available in the area and/or can continue to provide treatment as a result.

7) One retainer will be provided as a part of the scholarship award, any replacements will not be covered by Dr. Mark Paciorek, DDS, MS, PC or Smile for a Lifetime.

8) **Direct responsibilities of the patient:**

a) Maintain excellent oral hygiene (tooth brushing, Flossing). If unwilling to meet expectations, due to medical and dental health risks treatment will be discontinued.

b) Follow the rules for eating habits. This will greatly reduce breakage of appliances (i.e. braces) and it is necessary for satisfactory completion of treatment.

c) Cooperate. More than two (2) loose brackets may be deemed sufficient evidence that cooperation is not sufficient to meet minimal requirements for treatment.

d) Other cooperation issues are with failure to cooperate with maintenance of auxiliaries including elastics, wearing head gear, and springs.

e) Attitude. You will be expected to maintain an exceptionally appreciative and respectful attitude once accepted into orthodontic treatment or any other aspect of treatment supported by Dr. Mark Paciorek or Smile for a Lifetime. Rude behavior or an inappreciative attitude is unacceptable.

9) **ATTENTION:** Failure to comply to your responsibilities may result in removal of orthodontic equipment and discontinuation of treatment **Applicant Initials:** _____

10) **ATTENTION:** Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program. Future applications will not be considered. There are many deserving children who are in need of orthodontics we are here to serve those in greatest need. **Guardian's Initials**: _____

10) **Media Disclaimer**: If your child is the chosen applicant, you consent to Smile for a Lifetime's (S4L) use, without charge, of all photos, video and audio recordings of your child. S4L may,

a) Copyright, broadcast, display, publish, re-publish and reproduce your child's image, voice and any statements made by him/her, in whole or in part, in any and all media forms; and

b) Assign your child a fictitious name or use his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with S4L for fundraising or other promotional and advertising purposes. You and your child also agree to participate in surveys and case management during and after receiving treatment.

11) Legal Guardian Consent: I certify that I am the legal guardian of the child listed on this application. I have all rights and authority to make medical decisions for the child, that all information in this application is true and correct.

This scholarship is intended specifically for underserved and deserving children in the community. There are many children who need and deserve an award winning smile and while we do our best to serve those greatest in need, it is a competitive process and not everyone will receive a scholarship.

Please take your time on your application, your time and effort will be taken into consideration when selecting applicants for scholarships.

Applicant's Name (Printed First, MI, Last)	Applicant's Signature	Date
Guardian's Name (Printed First, MI, Last)	Guardian's Signature	Date

DENTAL REFERRAL FORM

Dear Dental Care Provider,

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

Your patient is applying for an orthodontic scholarship. ***If selected***, the patient will receive free braces through the Smile for a Lifetime Foundation. As the child's dental care provider, it is very important we receive feedback from you in regards to your patient so we can determine whether or not they will be a good candidate for our program. If the form is incomplete, the application cannot be included in the selection process.

To be filled out by the applicant's dentist. This form is to be completed prior to submitting application.

Patient Name:	Last	First	Middle	
Dentist's Name:	Last	First	Middle	
Dentist's Address:	Street	City	State	Zip Code
Dentist's Contact info:	Office Phone Number	Alternate Number	Email address	

General Information:

Does the patient need restorative work at this time? Please circle one.									Yes	No
Does the patient have good oral hygiene?	Yes	No	Does the patient have baby teeth:	Yes	No	If so, how many?				
Impacted Teeth:	Yes	No	If so, how many:		Missing Teeth:	Yes	No	Have second molars erupted:	Yes	No
Other Functional or Aesthetic Issues/ Additional Comments:										

How long have you been treating the patient:

Does the patient have a positive and respectful attitude:

Does the patient keep appointments: (please circle one)	Always	Mostly	Sometimes	Rarely	Never

Functional:

Malocculusion:	Class I	Class II	Class III
Crowding:	Mild	Moderate	Severe
Spacing:	Mild	Moderate	Severe
Overjet	Normal	Moderate	Severe
Underjet	Normal	Moderate	Severe
Overbite	Normal	Moderate	Severe
Underbite:	Normal	Moderate	Severe
Crossbite	None	Anterior	Posterior

Misalignment:	None	Mild	Moderate	Severe

Dentist's Signature	Dentist's Full Name	Date

MY PLAN TO "PAY IT FORWARD"

In our community, and all over the world, there is a great need for a great many of things. Being able to help those in need raises awareness and

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

hope in the community and gives us, as individuals, the opportunity to reflect on our own needs versus those of others. We would like to hear from you! Take some time to reflect on the needs of your community. This will take some time and research on your part. Read your local newspaper, talk to a teacher or friend and choose a non-profit /charitable organization you feel you can impact the most in your community or the world. Think of it as a business plan for your soul!

Note: It is important to find something that touches your heart and you are passionate about. For instance, if you love animals, help at a local animal shelter. If you relate to being hungry or even homeless, find a shelter or food bank you can support. The most important thing is that you connect to your community and know that you are making a difference.

Here are some ideas for you to get started:

Collect and donate goods:

Check with a local charity, church, shelter, humane society or orphanage if they anything.

1) Non-perishable food, hygiene items, clothing or toys they are in need of.
2) Check around your house and see if there are things that are gently used/loved but no longer need.
3) Check with neighbors, let them know what you are doing and ask if they can help.
4) Collect treats, magazines, and hygiene items for soldiers deployed overseas or something to remind them of home.

Donate your time:

Check with a local charity, church, shelter, humane society or orphanage if they need volunteers. Every little bit helps.

1) Sweeping, Mopping or reorganizing can help considerably when it comes to redistributing goods.
2) Take dogs for a walk or refilling their water and food dishes. Just petting and spending time with them so they know they are loved.
3) Everyone has a neighbor who is in need of light house work, or maybe yard maintenance that's been put off because of injury.
4) If you like art or poetry, write letters to soldiers for holidays or a draw a picture for thanks.

For more specific non-profits in your area, please go to:

WWW.ALLFORGOOD.ORG	WWW.SERVE.GOV	VOLUNTEERMATCH.ORG

Make note of the information you find, it will help you complete your Plan to pay it forward!

Name of Organization:	Who you spoke with:
Address:	Phone Number:
What they do, what are their goals:	
What they need help with:	
Commitment (How many hours a month and for how long):	
Age requirements, if any:	
Do they have an orientation, If so, When:	
Additional Information:	

MY PLAN TO "PAY IT FORWARD"

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

***HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.**
Who: Name of organization. Type of organization, who did you speak with? What is their mission statement? What are their short and long term goals? Etc.
What: What does the organization need help with? What will you be doing? Are there other volunteers? Do they have orientation? Etc.
When: When will you volunteer? What hours and days will you be there? What commitment is required by the organization, if any? What amount of time
have you committed to volunteering? Etc.
***If the minimum requirements are not met, your application will be considered incomplete and not included in selection process**

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

MY PLAN TO "PAY IT FORWARD"

***HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.**

Where: Where is the organization located? Is there more than one office? Do they have different departments? Which department will you be working in?

Are there other departments you would be interested in volunteering in? Etc.

How: How will you get to your organization? Do you have a backup plan? Are there ways you will prevent being late or missing the commitment you made

to the organization? Etc.

Why: What is most important to you about helping this organization? Do you have a story that relates to why you want to help them? Etc.

***If the minimum requirements are not met your application will be considered incomplete and not included in selection process.**

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

EXAMPLE

Who:

I spoke with Jane Doe at "Lost Dogs" which is a local animal shelter in Boise, Idaho. Jane is the manager at lost dogs. There are a lot of things she needs help with at the facility. Their mission statement says "A kindhearted society is where animals are respected, cared for and valued." I think it's very accurate because all animals should be loved. They currently house 52 cats and 27 dogs. They want to help at least 10 animals find a home by the end of the month and to match at least 100 animals with adoption families a year. In the next three years they would like to open another Lost Dogs animal shelter in Lewiston, Idaho.

What:

When I spoke with Jane Doe at Lost Dogs, she said that she needs help with things like changing food and water dishes. I will also be able to pet the animals and take them for walks or to the play area outside. They have several kids my age who are also volunteers. Their next orientation is on January 1st, 2014 at 1:00pm. That is when I will learn more about Lost Dogs and have a better idea of what I will be doing at the shelter. Once I am trained, I will be able to help wash and shampoo the dogs. I hope that next year, when I am old enough, I will be able to volunteer as a Kennel Assistant.

Where:

The Lost Dogs shelter is located at 1234 Main street, Boise, Idaho 10445. There are several departments within Lost Dogs that take care of many different needs of the animals that live there. The media department, for example, they help raise money for the shelter so they can buy food and supplies. There is also an education and community department which helps put the word out about the importance of spaying and neutering your animals. I will be working in the caring for animals department and as a small animal room assistant.

When:

Lost Dogs animal shelter asks that we commit to at least eight hours of volunteering a month, for at least six months. This is because it takes time to train the volunteers and they need people they can count on. I have committed to serve a minimum of four hours every weekend. I will arrive at Lost Dogs at 10:00 am and leaving at 2:00 pm. I will do this for at least ten months. If time allows, I would like to volunteer more hours during the summer. Mrs. Doe says that more animals show up during summer months, so there is more that needs to be done. There is also more that needs to be done because most of the fundraising and community events happen in July, August and September.

How:

My aunt works at Lost Dogs. She will take me to the shelter on the weekends so I can volunteer. My mom and dad have also agreed to help take me on the weekends when my aunt cannot. I have money kept in my room to take the bus just in case my aunt or parents cannot take me. Maybe, I will meet new friends and we can arrange a carpool to help my parents out with the cost and time of travel. I will do everything I can to fulfill my commitment because I understand what it means to pay it forward and that Lost Dogs is counting on me and so are the animals.

Why:

I love animals! I think they are amazing. I am really looking forward to volunteering at lost dogs. Last year, we had lost our cat Fluffy. We looked everywhere for him, we even posted flyers and asked neighbors if they had seen him. It was really sad because I have had fluffy since I was two and I was worried he wouldn't come home. Thankfully, Mom called Lost Dogs about a week later to find that someone had brought fluffy to the shelter. It was the wonderful people at Lost Dogs who had taken such good care of him. I want to be a part of caring for animals while their families are trying to find them and bring them home. I know how much it meant to me etc…..

Parent/Advocate Commitment Letter

What would this opportunity to mean to you as a parent?

Dr. Mark Paciorek 5099 W. Genesee Street
315-487-3335

How are you going to commit to this journey with your child?