Start a Smile®
FOUNDATION
Your smile is just the start!™

START A SMILE SCHOLARSHIP APPLICATION

You must submit a series of two photos:
1. A head-shot photo of the applicant with a full smile and teeth showing.
2. An up close photo of the applicant's mouth wide open and teeth showing.

You must have two letters of reference (these letters cannot be from a family member, they must be from a family friend, neighbor, teacher, etc.)

The four items above must be included with this completed application and Supplemental Questionnaire sheets.

APPLICANT AGE MUST BE 17 YEARS OR YOUNGER.

Applicant Name: _____ Date: _____

Applicant age: _____ Date of Birth: _____ Grade Level: _____ Gender: M F (please circle)

Street Address: _____

City: _____ State: _____ Zip: _____

Number in household: _____

CONTACT INFORMATION:

Parent/Guardian Name(s): _____

Street Address *(if different than applicant)*: _____

City: _____ State: _____ Zip: _____

Relationship to Applicant: _____ Phone #: *Home-* _____

Cell- _____ Cell Phone Provider: **Sprint AT&T T-Mobile Verizon Cricket Other** _____

Parent/Guardian E-Mail Address: _____

Applicant E-Mail Address: _____

Annual Household Income: _____

Does applicant qualify for **Missouri Healthnet** for Kids? _____

Is applicant covered by dental and/or orthodontic insurance? Y N (please circle)

If yes, please specify company and policy ID #: _____

Has applicant applied for Start a Smile in the last 12 months? Y N (please circle)

*All applicants, pictures and supporting documents will not be returned; thus becoming the property of the Start a Smile Foundation. Notification of the scholarships will be made immediately following a quarterly meeting of the Board of Directors (as the schedule indicates below). If you are not selected, the letters of reference and photos will be kept for one year, but a new application will need to be submitted. We encourage you to reapply.

APPLICATION DUE DATES:

Applications Received	**Scholarship Selection**
January 1 - March 31	April
April 1 - June 30	July
July 1 - September 30	October
October 1 - December 31	January

Please mail the completed forms with pictures and reference letters to:

Start a Smile Foundation
c/o Cardinal Orthodontics
Attention: Makayla
9628 Manchester Rd.
Rock Hill, MO 63119
for Questions: 314-938-3701
startasmile@cardinalorthodontics.com

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APPLICATION QUESTIONAIRE

Applicant Questionnaire **must be hand written and answered by applicant only**.
Questionnaires that are submitted and completed by someone other than the applicant will be disqualified.

1) What would it mean to you if you received orthodontic treatment through Start a Smile? Why do you feel you are a deserving candidate for Start a Smile?

_____

_____

_____

_____

_____

_____

_____

2) Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? Do you do any community service or volunteer work? What are your goals and aspirations?

_____

_____

_____

_____

_____

_____

_____

3. Tell us about your family. How many people live with you and who are they?

_____

_____

4) Why do you want braces? What prevents you from getting braces now? How do you feel about your smile now? How do you think braces will improve your life now and in the future.

5) If you had a chance to do a favor for another person/organization, without any expectation of being paid back, what would you do and why?

If you need more space, please add up to one additional sheet of paper. ***Thank you.***

Brought to you by:

cardinal orthodontics

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