Smiles Change Lives

Program Overview and Application Process

Smiles Change Lives (SCL) is happy to provide this **once in a lifetime opportunity** for your child to receive braces.

QUALIFICATIONS: Your child must meet **ALL** qualifications to apply to the program.

- Be 7-18 years of age (must receive application prior to the **child's 19th birthday**)
- Have "good" oral hygiene and no unfilled cavities
- Have a moderate to severe need for braces
- Not be wearing braces currently
- Have a total household income **at or below** our financial guidelines as listed at www.smileschangelives.org/financial, which varies by geographic location (see page 4 for more information)
- Be willing to pay the **non-refundable $30** (USD) **application fee** and the **non-refundable $650** (USD) **Required Financial Investment** (per child)

APPLICATION PROCESS:

1. Prior to applying, check the SCL website to determine the availability of providers and average minimum wait times for your area. Unfortunately, we do not currently have providers available in some areas. Upon receipt of a **COMPLETE** application, the application will be reviewed and the family will be notified whether or not your child qualifies for the next step in the application process. **If your application is INCOMPLETE**, it will be returned to you and, in order to be considered for the program, **you will be required to submit a NEW complete application, including an additional $30 (USD) non-refundable fee**.

2. Once SCL has received a complete application, it will be reviewed by the SCL Review Panel and the family will be notified whether the child (i) meets initial qualifications for the program and is ready to move to the next step in the application process, which is being placed on a waitlist for a screening appointment, (ii) is declined for the program, or (iii) will need further evaluation (due to poor oral hygiene, dental development, or other potential issues).

3. If your child meets the initial qualifications for the program, SCL will work to assign the child with an orthodontic provider for a screening appointment to evaluate your child's orthodontic needs. Your general dentist/dental clinic will be asked to complete a Dental Referral Form at this time to be sent to the screening orthodontist for review. If there are no openings in your area, you will be notified that you have been put on a wait list and that we are working to locate a provider in your area for your child.

   NOTE: The waiting period for this step of the process varies and **can be longer than twelve (12) months** based on area demand. Likewise, treatment providers are limited in some areas, and **SCL cannot make any guarantees of placement with a provider**. **If a treatment provider has not been assigned BEFORE your child turns 19, he or she will be removed from the wait list and will no longer be eligible for treatment.**

4. Following the screening appointment, SCL will notify you if your child has been approved for treatment and who the treating provider will be (the screening orthodontists is not always the provider who will perform the treatment). , you will be notified and **will have 30 days from the date of the notification letter in which to pay the nonrefundable $650 (USD) Required Financial Investment.** We cannot accept partial payments. We cannot accept payments from Flexible Spending Accounts or Health Savings Accounts. If this fee is not received by SCL in full within 30 days of notification, your child will lose his/her placement in the SCL program and will not be able to re-apply.

   This financial investment secures your child's beautiful new smile. Likewise, when you pay the Required Financial Investment, you know that not only will your child benefit, but that you are also "paying it forward" to help the program be available to assist other families in the future.

5. Upon receipt of payment, your child will be assigned to an SCL treatment provider and will be on their way to a healthy, happy smile!

2405 Grand Blvd, Suite 300 | Kansas City, MO 64108 | Phone 816-421-4949

APPLICATION CHECKLIST

(Include this completed checklist with your application)

All of the items below must be **FULLY** completed and submitted to SCL for **EACH** child that is applying to the program. Use this checklist to indicate that you have included each required document; that each has been fully completed; and that all items are signed where required. **If your application is INCOMPLETE, it will be returned to you and in order to be considered for the program, you will be required to submit a NEW complete application, including an additional $30 non-refundable fee.**

- ☐ **Check the website** to determine the availability of providers and average minimum wait time for your area. www.smileschangelives.org/for-kids-and-parents/apply-for-braces/application-waiting-period. Unfortunately, we do not currently have providers available in some areas and cannot guarantee treatment with a provider even if your child qualifies. **Do not contact any SCL providers until you are instructed to do so by our office; this is grounds to be denied or removed from the program.** Note: if a child is 18 or older when he or she applies, please be aware that the chances of placement with a treatment provider are greatly reduced depending on provider availability/wait times in your area as treatment cannot be started after a child turns 19.
- ☐ **General Application** (pg 3-5)
- ☐ **Child "About Me" Page (REQUIRED):** (page 6) **Must be completed by the child and included with your application.** This will be shared with the screening orthodontist and is your child's opportunity to explain what this treatment would mean to him/her and why they are a good candidate for the program. **Additional letters of support may also be included (optional).**
- ☐ **Notice of Privacy Practices** (pg. 7 – MUST be signed by parent/guardian; child must sign if 18 or older)
- ☐ **Program Rules and Guidelines** (pgs. 8 - All items MUST be **initialed** by parent/guardian; child must initial if 18 or older)
- ☐ **Parent/Legal Guardian Consent** & **Hold Harmless** (pg. 9–MUST be signed by BOTH parent/guardian & child)
- ☐ **EIGHT (8) photos of the child are required** (see pgs 10-11 for examples). Photos must show the child's teeth CLEARLY and be in accordance with the guidelines described at: www.smileschangelives.org/for-kids/application-process/applicant-photos-explained. All **8 photos** must be PRINTED and have the child's full name written on the back of each photo. Color photos preferred.
- ☐ **Federal Tax Form 1040 OR a Supplemental Security Income Awards Letter (US) / or a T4 and Tax Assessment or Canada Child Benefit Form (Canada)**. (See page 4 for additional information on this requirement). Proof of income MUST be submitted in the form of either a COMPLETE copy of the most recent year's federal tax return (include **ALL** pages) OR a copy of a current Supplemental Security Income Awards Letter (US) or a Canada Child Benefit Form (Canada). [Note: we **do not** accept Social Security *benefits* letters as proof of income] Tax forms/Social Security Income Awards Letters that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted**. **If you are submitting applications for more than one child, you MUST include a copy of your tax form OR Supplemental Security Income Awards Letter with EACH application.**
- ☐ **$30.00 (USD) non-refundable application fee** (check or money order; payable to **Smiles Change Lives**)

*** Documentation required for non-parental guardians (i.e. foster parents, foster agencies, and court appointed guardians):**

- ☐ Non-parental guardians must submit a copy of their authorization to make medical decisions (e.g. court order).
- ☐ For children in state custody, copies of the child's state medical card and medical consent must be submitted.
    - **A child in state custody is NOT required to submit proof of income.**

Mail COMPLETE application to:
Smiles Change Lives, 2405 Grand Blvd, Suite 300, Kansas City, MO 64108
Please ensure you use adequate postage and keep a copy of your completed application for your records.

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GENERAL APPLICATION

(To be completed by PARENT/GUARDIAN; please write clearly)

I. CHILD'S PERSONAL INFORMATION

_____ _____ _____ Gender: □ Male □ Female

Child's First Name | Child's Last Name | Child's Date of Birth

_____

Street Address | City | State | Zip

II. PARENT/GUARDIAN'S PERSONAL INFORMATION

_____ _____ _____

Custodial Parent/Guardian First Name | Last Name | Relationship to Child

_____ _____ _____

Cell Phone # | Home Phone # | Email **(required)***

***Email is the most effective way to communicate with you regarding your child's status. Please make sure this is a valid email address and that you notify SCL if your email address changes at any time.**

_____

Address (if different than child's) | City | State | Zip

Marital Status: _____ Spouse/Partner's Name: _____ Relationship to Child: _____

If child doesn't live with both parents, name of non-custodial parent: _____

FOR NON-PARENTAL GUARDIANS, you **MUST** submit a copy of your medical authorization (e.g, court order, letter of authorization, etc.). For children in state custody, submit a copy of their state medical card and consent.

III. OTHER INFORMATION

Have any of the child's family members applied to or been treated through SCL? If yes, please list their name(s):

_____

We attempt to place children as close as possible, but search up to a 100 mile radius for available treatment providers. If necessary, are you willing to travel farther? □ yes □ no

Please list any health issues your child has that we should be aware of: _____

_____

IV. DENTAL HEALTH CERTIFICATION Good oral hygiene is a prerequisite for approval to the program ("good oral hygiene" means brushes and flosses regularly and does not have any known gum disease or unfilled cavities). Prior to your child's screening with an orthodontist, your child's dentist/dental clinic will be asked by SCL to complete a Dental Referral Form based upon their most recent exam. Your child's application may be rejected if your child does not have good oral hygiene to SCL's satisfaction.

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GENERAL APPLICATION CONT.

(To be completed by PARENT/GUARDIAN; please write clearly)

Does your child get dental exams ? □ Yes □ No How often do they typically get a dental exam: _____

Name of child's dentist/dental clinic:_____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Is your child currently wearing braces? □ Yes □ No Do they have good oral hygiene □ Yes □ No

V. Why Does Your Child Need Braces (select all that apply)

_____ difficulty eating and/or drinking

____ pain in mouth and/or jaw

____ people make fun of teeth

____ unable to clean teeth very well

VI. FINANCIAL: You **MUST** submit a copy of the most recent year's **Federal Tax Form 1040 OR a Supplemental Security Income Award Letter as proof of income (US) or a T4 and a Tax Assessment form or Canada Child Benefit Form (Canada).** [Note: we **do not** accept Social Security benefits letters as proof of income.]
For 1040:

- Line 11 on 1040 must show adjusted gross income at or below the financial guidelines listed on SCL website to qualify.
- The child applying MUST be listed as a **dependent** on page one of Form 1040 or on an additional statement of dependents along with the child's Social Security number.
- Please be sure to include a complete copy of the tax form (typically 2 pages) to be sure all necessary information is included.

If the child applying is not claimed as a dependent on your tax return, you must explain why and submit the tax return for the person who DOES claim the child, as well as proof of where the child resides (e.g. school records). In this situation, BOTH tax returns must be submitted and **each** must **separately** meet our financial qualifications._____

VII. HOW DID YOU HEAR ABOUT SMILES CHANGE LIVES? Please include details where possible.

_____ Web search- what words or phrases did you search? _____
_____ Website- name of site or organization _____
_____ Family/Friend-name _____ Were they an SCL participant? □ Yes □ No
_____ Dentist (your regular dentist)-name/location _____
_____ Dental school/clinic-name/location _____
_____ Orthodontist-name/location_____
_____ Newspaper/magazine-publication name _____ date _____
_____ TV/Radio-station name _____ date _____
_____ Event (example: health fair) please describe _____ date _____
_____ Other-please describe _____

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GENERAL APPLICATION CONT.

(To be completed by PARENT/GUARDIAN; please write clearly)

IIIV. PARENT/GUARDIAN QUESTIONNAIRE (answers to be completed by parent/guardian completing application; please write clearly)

SCL is a nonprofit program that seeks to help children who may otherwise not be able to receive orthodontic treatment. Please answer the following questions in order to share additional information for consideration in evaluating your child's application (if you need additional space to answer, please include a separate piece of paper):

Since not everyone who applies is accepted, why should your child be selected for treatment through SCL?

_____

_____

_____

Please share any personal background information regarding you and/or your family's situation that you would like considered.

_____

_____

_____

What do you hope will be the outcome if your child receives braces through SCL?

_____

_____

_____

Is there any other information about your child you would like to share:

_____

_____

_____

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CHILD'S "ABOUT ME" QUESTIONNAIRE

(To be completed by child/applicant; please write clearly)

Why do you want braces? _____

_____

_____

What do you want to be when you grow up?_____

What is your favorite:

Food:_____
Color:_____
Hobby:_____

One fun fact about you: _____

How would having braces make your life better? _____

_____

_____

Since not everyone who applies is accepted, is there anything special you want to share about why you should receive braces through SCL?

_____

_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your protected health information may be used by staff members, volunteers, agents and national and advisory board members of the Virginia Brown Community Orthodontic Partnership d/b/a Smiles Change Lives and disclosed to other health care professionals, including but not limited to your assigned screening and treatment provider(s), for the purpose of evaluating your application and providing your treatment.

Program Operations: Patient information, including first name, case history and photographic images may be used as necessary to support assessment, public relations, fund development and other activities of Smiles Change Lives.
Law enforcement: Your protected health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Public health reporting: Your protected health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
Other uses and disclosures require your authorization: Disclosure of your protected health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you noticed us of your decision to revoke your authorization.
Individual Rights: You have certain rights under the federal privacy standards. These include: The right to get an electronic or paper copy of your record ▪ The right to request confidential communications ▪ The right to request restrictions on the use and disclosure of your protected health information ▪ The right to inspect and copy your protected health information ▪ The right to amend or submit corrections to your protected health information ▪ The right to receive an accounting of how and to whom your protected health information has been disclosed ▪ The right to receive a printed copy of this notice ▪ The right to file a complaint.
Smiles Change Lives Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice and to notify you when a breach of your unsecured protected health information has occurred.
Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.
Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting SCL at the address below.
Complaints Contact Information: If you would like to submit a complaint or have questions regarding our privacy practices, you may contact us in writing at the following address: Smiles Change Lives, 2405 Grand Blvd, Suite 300, Kansas City, MO 64108, or you may also contact the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after 05/01/2005.

I, _____ have received a copy of Smiles Change Lives' Notice of Privacy Practices.
Custodial Parent or Legal Guardian **PRINTED NAME**

_____ _____
Custodial Parent or Legal Guardian **SIGNATURE** **DATE** (mm/dd/yyyy)

Child Consent: (Child <u>MUST</u> sign if 18 years of age or older)

_____ _____ _____
Date (mm/dd/yyyy) Child/Applicant SIGNATURE *(Not Parent/Guardian)* PRINTED NAME

Program Rules and Guidelines

Smiles Change Lives (SCL) is happy to provide this **once-in-a-lifetime** opportunity for your child to receive braces – it is an opportunity that many children do not receive. However, we will only provide treatment if you and your child fully cooperate with the treatment provider and his/her treatment plan. All of the following conditions must be met to be eligible to start treatment and to continue treatment. **PARENT/ GUARDIAN: PLEASE READ CAREFULLY AND INITIAL EACH ITEM. IF CHILD IS 18 OR OLDER, CHILD MUST ALSO INITIAL.**

_____ 1. SCL provides for orthodontic treatment ONLY. Extractions, cleanings, oral surgery, x-rays, panorex or other treatment that may be necessary before, during or after orthodontic treatment are the financial responsibility of the participant's parents or legal guardians.

_____ 2. To be a part of this program your child must have good oral hygiene and not have any unfilled cavities. If your child has unfilled cavities or periodontal disease, these conditions must be completely remedied before treatment is started. Your child must have regular dental cleanings every six months during treatment. During the course of treatment, if your child's teeth are not cleaned properly, cavities can form around the braces. **Your child may be removed from the program at any time due to poor oral hygiene.**

_____ 3. Treatment providers are limited in some areas and **SCL cannot make guarantees of placement with a provider even if your child qualifies for the program**. Waiting periods vary and **can be longer than twelve (12) months** based on area demand. During this time, you may be required to submit updated documents, including a 1040/Supplemental Security Income letter to ensure your child still qualifies for the program. **Due to the high number of applicants and limited treatment spots open, SCL may search up to a 100 mile radius when assigning your child.**

_____ 4. If a provider is located, the parents/guardians agree to submit the nonrefundable **$650 (USD)** Required Financial Investment upon notice from SCL. If payment is not received within **30 days** of such notice, your child will lose his/her place in the program. **SCL makes all provider assignments at its sole discretion and you agree to receive treatment from the provider assigned.** If a treatment provider has not been assigned BEFORE your child turns 19, he/she will be removed from the program and will no longer be eligible for treatment. Note: we cannot accept payments from Flexible Spending Accounts or Health Savings Accounts.

_____ 5. Once accepted and the $650 is received, your child will begin treatment with the assigned SCL treatment provider. Treatment is only available from the assigned provider, who is donating his/her time and all materials/supplies required to provide full treatment for your child. Typically, the average cost of braces NOT acquired via Smiles Change Lives is $6,000. Note: once the $650 payment is received, it is non-refundable and will not be returned if your child is removed from the program in accordance with the program rules and guidelines.

_____ 6. Regular appointments are required to make sure teeth move as expected. Since the treatment provider is donating treatment, s/he may require you to attend appointments during non-peak hours. As a result, your child's appointments will likely be scheduled during the mid-morning or mid-afternoon hours. It is your responsibility to make sure that all scheduled appointments are kept. If you must cancel or reschedule an appointment, you are required to give your doctor at least 24 hours notice. **Not calling to cancel or missing an appointment is grounds to remove your child from the program and have your child's braces removed**.

_____ 7. You and your child must fully follow the treatment plan set by your treatment provider, which will be explained to you before treatment starts. If you fail to follow the treatment plan, including but not limited to proper use of bands, appliances, and retainers, the treatment provider has the option to refuse to continue treatment and to remove braces. You further agree to comply with all health and safety protocols set by the assigned treatment provider's office, including those related to Covid-19. It is your responsibility to be aware of the protocols in place prior to paying your RFI and your child beginning treatment. Failure of you or your child to comply with the treatment provider's Covid-19 safety protocols will result in your child's immediate removal from the program without refund of your $650 RFI.

_____ 8. If you move before treatment concludes, please call us in addition to telling your treatment provider. You will be removed from the program and will be responsible for making arrangements to complete your child's care. You may either have your SCL treatment provider remove the braces or you may locate a new treatment provider in your new community for which you will be financially responsible. SCL is not responsible for locating a new treatment provider or paying for continued treatment.

_____ 9. **Providers donate their services based upon your child's qualification for the SCL program, both in terms of orthodontic and financial need. As such, it is important that you treat the provider and his/her staff with respect, express your gratitude for their services and behave in a way that reflects positively on both SCL and your family at all times.**

_____ 10. Your child may be removed from the program at any time (this includes during the application process, before assignment to a provider and after treatment has started) if the child or parent/guardian is **uncooperative** or **disrespectful** to SCL staff or the provider and his/her staff, or fails to comply with any SCL rules and guidelines. During the course of treatment, the provider may, at his/her discretion, refuse to continue treatment and may remove the child's braces. If removed for cause, your child is no longer eligible to reapply to the SCL program.

_____ 11. Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must not eat hard or sticky foods or pull on the braces. **If there is frequent damage to the braces, the treatment provider has the option of removing the braces or charging you to repair the damage, which is not covered by this program.**

_____ 12. One (1) retainer device will be provided as part of the treatment program at no charge. **If this retainer is lost or damaged, you will be charged for a replacement.**

_____ 13. If your child is accepted into the program, you consent to SCL's use, without charge, of all photos, video or audio recordings of you and your child. SCL may (1) copyright, broadcast, display, publish, re-publish, and reproduce you and your child's image, voice and any statements made by you and him/her, in whole or in part, in any and all media forms; and (2) assign you and your child a fictitious name or use your or his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with SCL, for fundraising or other promotional and advertising purposes. You and your child agree to participate in surveys and case management during and after treatment.

_____ 14. SCL coordinates all communication between families/children and the treatment providers. Do **NOT** contact a provider unless instructed by SCL. **If you contact a provider without permission, your child may be removed from the program.**

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Consent and Hold Harmless Agreement

The undersigned has read, understands and agrees to abide by the attached **Program Rules and Guidelines,** which are incorporated herein by reference, for receiving orthodontic treatment through the Virginia Brown Community Orthodontic Partnership d/b/a **Smiles Change Lives**, and has been given the opportunity to ask questions about this information. If our application is approved and a treatment provider is located, I consent to allow Smiles Change Lives and its partner doctors to provide orthodontic treatment for my child. I understand that acceptance into the Smiles Change Lives program for my child's orthodontic care is based on our (my child's and my) ability to maintain my child's oral health as indicated in the Program Rules and Guidelines and to abide by all the Program Rules and Guidelines. **I also understand that if we do not maintain oral hygiene and abide by the Program Rules and Guidelines, my child will be removed from the program, his/her braces will be removed and treatment will be terminated with no refund of the $650 Required Financial Investment.** I further agree that if treatment is stopped early and my child is removed from the program for not following the Rules and Guidelines, or for any other reason, we (my child and I) will hold Smiles Change Lives and the assigned treatment provider harmless and free from any liability for any damage or injury resulting from the termination of said treatment.

I, on behalf of myself and my child, acknowledge that Smiles Change Lives does not itself provide the orthodontic treatment and that all treatment will be provided by a doctor assigned by Smiles Change Lives ("partner doctor"). I expressly authorize Smiles Change Lives, the partner doctor(s) and my dentist (as listed on my application) to share my child's medical records and information with each other in order to coordinate and manage my child's treatment. In consideration of the acceptance of my child's application by Smiles Change Lives, we (my child and I) release Smiles Change Lives and the partner doctor and their agents, employees, board members, officers, representatives, and successors and assigns from any and all claims, demands, actions, proceedings, damages or liability of any kind whatsoever that we may have at any time arising, directly or indirectly, from (i) our participation in the Smiles Change Lives program, or (ii) any action taken by Smiles Change Lives or the partner doctor based on the Program Rules and Guidelines, including but not limited to my child's removal from the program and the removal of his/her braces. I further acknowledge and understand that Smiles Change Lives and the partner doctor do not guarantee satisfaction with the outcome of the orthodontic treatment provided.
I consent and authorize receipt of all communication from Smiles Change Lives via email to the email address provided by me in my child's application, or as updated by me in writing to Smiles Change Lives from time to time. I understand that it is my responsibility to maintain a valid email address on file with Smiles Change Lives for this purpose.

This Agreement shall be interpreted and enforced in accordance with the laws of Missouri and is intended to be as broad and inclusive as permitted by the laws thereof or of any other state where Smiles Change Lives program activities occur. Waiver of any provision by Smiles Change Lives shall not operate or be construed as a continuing waiver. This Agreement shall survive termination or completion of my child's treatment. If any portion of this Agreement is held invalid, the remainder of it shall remain effective.
YOUR SIGNATURE INDICATES THAT YOU HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE CONSENT AND HOLD HARMLESS AGREEMENT.

Custodial Parent or Legal Guardian Consent: I further certify I am the custodial parent or legal guardian for the child named below, that I have legal authority to make medical decisions for the child, that all the information enclosed in this application is true and correct and that all income is reported. I understand that deliberate misrepresentation will not be tolerated and will result in permanent dismissal from the program.

Your signature must be hand written. Electronic signatures are not acceptable.

Date (mm/dd/yyyy)	Custodial Parent or Legal Guardian SIGNATURE	PRINTED NAME

Child Consent: (Child MUST sign even if under 18 years of age)

Date (mm/dd/yyyy)	Child/Applicant SIGNATURE (Not Parent/Guardian)	PRINTED NAME

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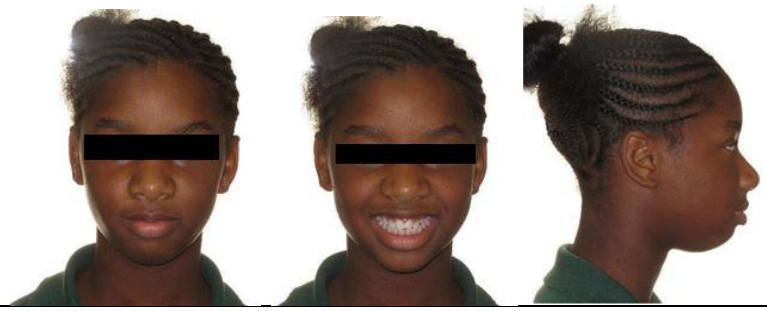
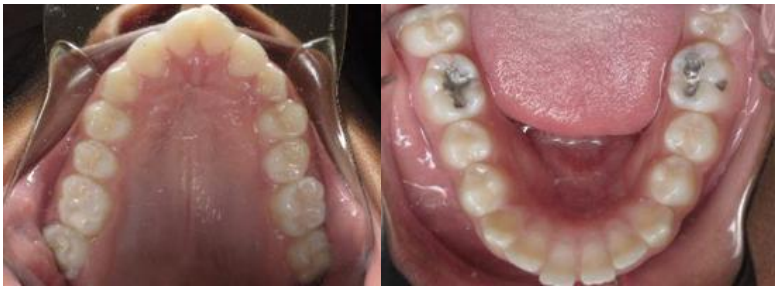
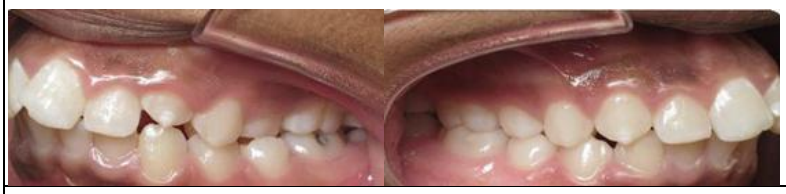
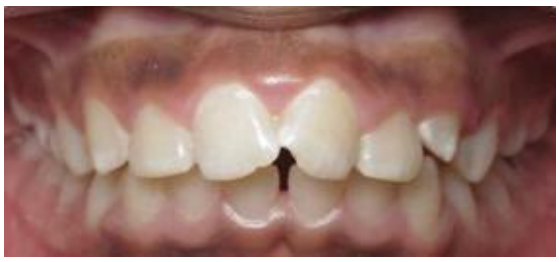
REQUIRED PHOTOS

These photos are extremely important and must be as clear as possible in order for us to assess your child's unique treatment needs. Keep in mind that they will be sent to your potential treatment provider for evaluation prior to being accepted for treatment. You may use photos provided to you by your dentist, or you may take your own using a regular camera or a camera phone, provided the photos are of good quality. Please make sure your child has brushed and flossed prior to taking the photos.

Please take your time when taking the photos, and send in ALL 8 required photos. **We MUST have all 8 photos in order for your application to be complete.** The following photos are the eight angles required in our application. *You do NOT need to darken out your child's eyes in the pictures you send to us (we do this for the privacy of our model).

	**1, 2 & 3** Please take the following three photos. **1)** A full head shot of your child looking forward with the mouth closed naturally. **2)** A full head shot of your child looking forward and smiling naturally. **3)** A full head shot of your child's side profile with their mouth closed naturally. *<u>It is not necessary to block out the eyes on your child's photos.</u>
	**4 & 5** Upper and lower teeth. These two photos are generally taken from a lower/higher angle with the child's mouth open as wide as possible and lips pulled back, or by carefully placing a small compact mirror in the child's mouth at an angle and photographing the reflection. These pictures help us identify any spacing or crowding issues.
	**6 & 7** Bite from side. Please have your child bite down naturally and use an object (spoons, pencil, etc) to pull the lips back. Both the left and right side of the mouth needs to be shown. These pictures tell us about the alignment of the molars as well as over/under bites or protrusion of the teeth.
	**8** Photo of teeth from the front with natural bite. Take this photo of your child's teeth from the front - with the lips pulled back using the same method as in photos 6 & 7. These pictures tell us about the alignment of the teeth, the natural bite, and any rotation of the teeth, as well as identifying any crowding or spacing.

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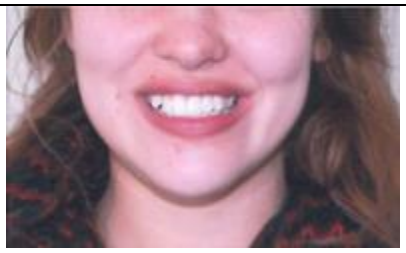
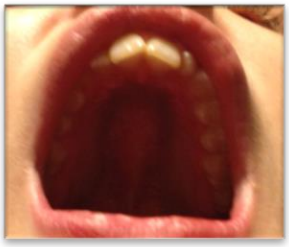
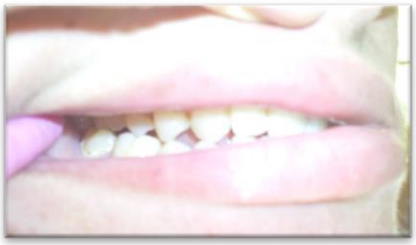
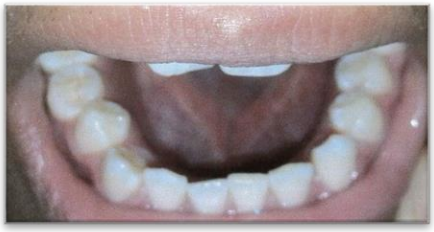
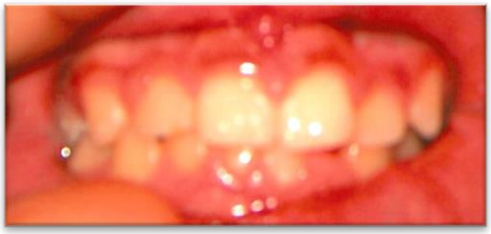
Please DO NOT send photos like those shown below

	**Partial head shots** Head shot photos must show the whole head.
	**Photos where the teeth aren't visible** Lips need to be pulled back in order to see the teeth and alignment.
	**Overexposed or blurry photos** Lips need to be pulled open so that teeth are fully visible. Photos need to be exposed so that we can see teeth clearly.
	**Photos that don't show natural bite** Close your teeth naturally so that we are able to assess your bite.
	**Photos that don't show all the necessary teeth** Mouth is not open wide enough for us to see the molars.
	**Blurry, tinted photos, or photos with filters** Photo is blurry, and the red tint makes it difficult to evaluate any potential tooth rotation.

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