



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 KanCare or Missouri Healthnet for Kids? \_\_\_\_\_ (if yes, please circle)

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 (or Smile for a Lifetime) 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:

Table with 2 columns: Applications Received and Scholarship Selection. Rows include dates from January to December.

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

Start a Smile Foundation
c/o Fry Orthodontic Specialists
Attention: Makayla
11880 College Blvd. Ste. 201
Overland Park, KS 66210
for Questions: 816-280-4521
startasmile@fryorthodontics.com





## APPLICATION QUESTIONNAIRE

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?

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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?

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

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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.

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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?

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

Brought to you by:

**FRY** Orthodontic  
Specialists  
-Since 1977-

*Your smile is just the start!*