



**NATIONAL CHILDREN'S ORAL HEALTH FOUNDATION
AFFILIATE APPLICATION FORM**

- 1. FACILITY NAME:
STREET ADDRESS:
CITY, STATE, ZIP CODE**

- 2. MAIN PHONE:
PRIVATE LINE:
FAX:**

- 3. DIRECT CONTACT PERSON:
TITLE:
EMAIL:**

- 4. TAX # :**
*PLEASE ATTACH AN IRS LETTER OF DETERMINATION WITH THIS APPLICATION

- 5. WEB ADDRESS:**

- 6. HOURS:**

- 7. MISSION STATEMENT:**

- 8. PROGRAM PRIORITIES:**

- 9. TYPE OF FACILITY (check all that apply):**
 - Comprehensive Community Healthcare Facility _____
 - Hospital-Based Dental Program _____
 - Mobile / Portable Dental Program _____
 - Stand Alone Dental Clinic _____
 - University _____
 - School-based Program _____
 - Partnership (Assessment, triage, referral, and education) _____

- 10. PATIENT POPULATION:**
 - 1. Total number of individual patients (in most recently completed fiscal year):** _____
 - 2. Total number of patient visits per year (in most recently completed fiscal year):** _____
 - 3. By Payer Source:**
 - # or % government insurance (e.g., Medicaid, other state or local programs): _____
 - # or % private insurance: _____
 - # or % other payer (e.g., individuals covered under a foundation grant, funds from a local school district, etc.): _____
 - # or % uninsured or self-pay: _____

4. By age

or % ages 0-5: _____
or % ages 6-12: _____
or % ages 13-16: _____
or % ages 17-18: _____
or % ages 19-21: _____

5. By Ethnicity: Please provide US Census most recent comparison if available:

11. OTHER DEMOGRAPHIC / GEOGRAPHIC CHARACTERISTICS (information that may be helpful for NCOHF to understand the make-up of your patient population such as catchment area size: rural, suburban, or urban; poverty levels; unemployment rates; racial / ethnic breakdown for the community, etc.):

12. FACILITY CHARACTERISTICS (e.g., newly constructed, renovated; age; general appearance; functional allocation of space; etc.)

13. FISCAL INFORMATION (Please provide total budget with revenue sources [public funding, grants, etc.] / expense breakdowns for most recent fiscal year):

14. STAFFING (Please report as FTEs):

DDSs or DMDs: _____

RDHs: _____

RDAs or CDAs _____

Other Auxiliary Personnel (e.g., social workers, health educators, outreach workers [aka Promotoras], nutritionists, dieticians, etc.): _____

Support Staff (please list titles and functions):

Office Managers _____

Receptionists _____

Scheduling Coordinators _____

Finance Coordinators _____

Insurance Coordinators _____

Volunteers (Please list credentials – include health professions students, # of hours per week/month/year, and volunteer duties including health professions students, etc.)

CREDENTIALS	AMOUNT OF TIME	VOLUNTEER DUTIES
Example: DDS	4 hours per week	School screenings
Example: High School Student	5 hours per week	Sterilization

15. PROGRAMMING:

Clinical Treatment (scope of services, # of operatories, etc.): _____

Preventive (description): _____

Educational (description): _____

Community Outreach Programs (Please check all that apply):

School Oral Health Screenings/Exams	# Times / Year	# Children Served
<input type="checkbox"/> Head Start		
<input type="checkbox"/> Early Head Start		
<input type="checkbox"/> Childcare Centers		
<input type="checkbox"/> Mothers Morning Out		
<input type="checkbox"/> Elementary		
<input type="checkbox"/> Middle School		
<input type="checkbox"/> High School		
<input type="checkbox"/> Health Fairs		
<input type="checkbox"/> Boys and Girls Clubs		
<input type="checkbox"/> Scout troops		
<input type="checkbox"/> Mobile Unit		
<input type="checkbox"/> WIC		
<input type="checkbox"/> Other		

PLEASE PROVIDE:

- 1. Name, Title, and Contact Information of the Chief Executive Officer.**
- 2. Name, Title, Business Title and Affiliation, and Contact Information for the Chief Volunteer Officer (e.g., Board Chair).**
- 3. Brief Description, History and Background of the Organization.**
- 4. Evidence of Federal Tax-Exempt Status or 501(c)(3) Letter.** (A copy of the organization’s letter(s) from the Internal Revenue Service indicating the tax-exempt status and whether or not it is a private foundation under the 1969 Tax Reform Act. Governmental agencies need not submit a tax-exempt letter.)
- 5. List of Collaborating Partners (including role played by each).** _____

- 6. Description of the most recent Oral Health Assets / Needs Assessment survey for your community:**
 - a. When was it conducted?**
 - b. Who coordinated/participated?**
 - c. What were the results?**

- d. What assets currently exist to address these needs?
 - e. What measures have been taken to address these issues?
 - f. What else needs to be done to address these needs?
7. How can NCOHF assist your program with its mission and goals?
 8. What obstacles might your organization encounter?
 - a. How do you plan to overcome them?
 9. What factors will enable your organization to be successful?
 10. How will you determine if you have been successful?
 11. What will be different because of NCOHF support?
 12. How will the efforts be sustained?
 13. Where is the opportunity in your community to apply the educational programming (NCOHF's educational curriculum of choice, the Toothfairy Island[®] Curriculum)?

Affiliate applicants without the financial resources to cover the startup costs may submit a Statement of Need on your letterhead requesting "consideration of grant funds from the Toothfairy Island Campaign to defray the fee for start-up costs."

FOR MORE INFORMATION OR ANSWERS TO QUESTIONS:

NATIONAL CHILDREN'S ORAL HEALTH FOUNDATION
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