Pay It Forward Scholarship Application

SCHOLARSHIP QUALIFICATIONS

1. Must be between ages 10 and 18 and have good oral hygiene.
2. Applicant's parents must have a combined income level that is lower the 150% of the federal poverty level.
3. Have a moderate to severe need for braces.

APPLICATION REQUIREMENTS (TO BE SUBMITTED WITH THIS APPLICATION)

1. A 5x7 facial photo *(full smile with teeth showing)*.
2. Two letters of recommendation *(preferably from a dentist, teacher, clergy, etc.)*. No more than one typed page per recommendation.
3. Verification of parents' guardians income in the form of the previous years tax return.
4. Write a short essay on one page explaining "I would benefit because_____".

Number of times applicant has submitted an application to Pay It Forward Scholarship_____
Applicant's Age_____ Applicant's Grade In School_____Applicant's Birthdate _____

Does applicant qualify for Medicaid?_____
Is applicant covered by dental insurance? (*Specify company and policy # located on card*)_____

CONTACT INFORMATION

Applicant Name_____
Parent/Gaurdian Name_____
Address_____
Parent Email_____
Parent/Gaurdian Phone_____Cell_____
Parent/Gaurdian Place of Employment_____
Submitted by (*circle one*) Self Parent School Official Dentist Other _____

All applications, pictures, and supporting documents will NOT be returned and become property of Kevin Cook Orthodontics, LLC. It is further understood that names and photos will be used for professional presentations and official announcements.

Applicant Signature_____

Parent/Gaurdian Signature_____

Please mail completed applications with materials requested to:

Marion Office:
3108 W Deyoung St., Suite A
Marion, IL 62959

cookortho.com