ADA Foundation®

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ADA Foundation Charitable Assistance Grant Application for Dentists, Spouses of Dentists, and Dependents of Dentists under the Age of 18

Date: _____

Applicant Information

Applicant must be a dentist, spouse of a dentist, or dependent of a dentist under the age of 18 to be eligible for an ADA Foundation Charitable Assistance Grant. If you are **NOT** a dentist, spouse or dependent of a dentist under the age of 18, you **DO NOT** qualify for this Grant and should not apply. For details about eligibility, and the Program generally, please see the Rules, available at https://www.adafoundation.org/en/how-to-apply, or available upon request by contacting adaf@ada.org.

Full Name: _____

Current address: _____

City: _____ State: _____ ZIP code: _____

Primary phone: _____ Cell phone: _____

E-mail address: _____

Date of birth: _____ Age:_____ Marital status: _____

Dentist's name (if different than Applicant name): _____

State(s) where the dentist practice(d): _____

Number of adults in household, including self: _____ Number of dependents (under age 18): _____

Employment Status

Current employer (if applicable):_____

Month/year dentist began practicing:_____

If currently working, please indicate type of employment as well as how many days and hours per week, along with any other pertinent information about Applicant's work schedule:

Description of Hardship and/or Emergency

To help the ADA Foundation better understand your circumstances, please provide answers to the following.

Provide any supporting documentation to your responses as attachments.

1. What monthly dollar amount would you need, in the form of an ADA Foundation Charitable Assistance Grant, to make you financially stable?
   *(ADA Foundation assistance is only for **essential daily living expenses** or to cover the cost of **emergency living needs.** Please see Rules for details.)*

2. What specific life circumstance or event gave rise to your current need for financial support, and when did it occur? Provide as many relevant details as possible.
   (You may write on a separate piece of paper and attach to your application.)

3. Have you utilized, or do you plan to utilize, any personal benefits or resources to meet your needs? (Other resources available to you may include, but are not limited to, resources through your employer, 401(k) loan, long-term care insurance, disability, etc.). *(Attach documentation regarding these resources.)*

   ____Yes ____No

   Below, please explain the benefits that you plan to use, or why there are no additional resources available to you.

4. Below, please provide detail about what, if any, outside sources of support are available to you? *(Examples include, but are not limited to: family, community resources, Department of Aging, and VA benefits. Attach any documentation regarding these resources.)*

5. Have you or another household member previously applied for a Charitable Assistance Grant from the ADA Foundation?

   ____Yes ____No If so, when *(month/year)*? _____

Acknowledgement

By signing below, I represent and acknowledge the following:

- I am providing this information (above and attached) in conjunction with my application for charitable assistance from the ADA Foundation;
- The ADA Foundation does not promise to award to me any funds in connection with this application;
- I may be asked to provide clarification or additional information to supplement this application;
- Grants are awarded at the discretion of the ADA Foundation Charitable Assistance Committee pursuant to the Rules of the ADA Foundation Charitable Assistance Grant Program ("Rules");
- I have received a copy of the Rules, and I acknowledge and agree to their terms and conditions, including, but not limited to, the following: no Grant will be awarded based on an incomplete application, and my application will be denied if I knowingly provide inaccurate or misleading information in connection with this application; and
- The information in my application may be shared with a third party, including, but not limited to, the ADA Health and Wellness Division as well as state and local dental societies.

Check that you agree to the accuracy of details in this application:

- ☐ By checking this box, I acknowledge that I have applied for (or otherwise sought) all funding resources that may be available to me.
- ☐ By checking this box, I acknowledge that the information presented in this application is accurate and true to the best of my knowledge.

Print Name:_____

Signature:_____

Date:_____

Application Check List

Before submitting your application, check below to indicate that you have completed the following:

- ☐ Complete Appendix A ("Calculation of Monthly Household Net Income") – attached to the Application Form.
- ☐ Complete Appendix B ("Calculation of Net Assets and Liabilities") – attached to the Application Form.
- ☐ Confirm all application questions are answered and all responses are accurate.
- ☐ Sign and date the application.
- ☐ Attach any supporting documentation to the application including, but not limited to:
    - Tax returns
    - Checking/savings account information
    - Social Security benefits
    - Medicare/Medicaid benefits
    - Veterans benefits
    - Medical records related to this application
    - List of applications made for outside funding sources including federal, state and local governments. Also include responses from these entities, if applicable.

Incomplete applications will not be considered for funding by the Charitable Grants Committee.

Once the application is completed and all accompanying information is attached, send the documents to the following address: **ADA Foundation, 211 E. Chicago Avenue, Chicago, IL 60611; Attention: Tracey Schilligo**

If you have any questions about the ADA Foundation Charitable Assistance Grant application process, contact Tracey Schilligo, Professional Programs Manager, at 312.440.2763 or schilligot@ada.org.

Appendix A: Calculation of Monthly Household Net Income

Monthly Household Income (provide supporting documentation when available)	
Salary **(DO NOT INCLUDE ADA FOUNDATION GRANT)**	$
Partner/Spouse Work Income *(monthly income obtained by partner, spouse, or other family member in your household)*:	$
Additional Income **(DO NOT INCLUDE ADA FOUNDATION GRANT)** *(other monthly income obtained by you through additional jobs, alimony, child support, disability, insurance payments, etc.)* Please itemize with specific amount:	$
Veterans Benefits	$
Social Security Benefits	$
Insurance Benefits (including health, accident, and disability) Please itemize with specific amount for each type of insurance:	$
Retirement Distributions (IRAs, Keogh, etc.) Please itemize with specific amount for each retirement plan:	$
Interest and Dividends	$
Other Income **(DO NOT INCLUDE ADA FOUNDATION GRANT)** Please itemize with specific amount:	$
TOTAL **Monthly** Household Income	$

Monthly Household Expenses (provide backup documentation when available)	
Housing *(includes mortgage/rent, housing fees, and real estate taxes)*	$
Utilities *(includes gas, electric, water, sewer, primary phone, and basic cable)*	$
Food *(includes groceries, meals out, snacks, and beverages for the entire household)*	$
Clothing	$
Transportation *(includes monthly car payment and gas, and/or public transportation costs)*	$
Medical Not Covered by Insurance *(includes regular monthly out-of-pocket medical and/or dental expenses, and over-the-counter or prescription medication)*	$
Insurance Payments *(includes, but is not limited to: health, life, auto, and home)* Please itemize with specific amount for each type of insurance:	$
Childcare *(includes out-of-pocket expenses for childcare not subsidized for minors/elders in your household during work hours)*	$
Other Please explain and itemize with specific amount:	$
TOTAL **Monthly** Household Expenses	$

NET MONTHLY HOUSEHOLD INCOME (total monthly Income minus total monthly Expenses)	$

Appendix B: Calculation of Net Assets and Liabilities

Assets	
Current Checking Account Balance *(please list all banks and checking accounts)* Bank name(s):	$
Current Savings Account Balance *(please list all banks and savings accounts)* Bank name(s):	$
Real Estate	$
Life Insurance (cash value) List the beneficiaries of each policy below:	$
Investment Accounts (stocks, bonds, mutual funds, etc.)	$
Business Interests (including dental practice) Please explain and itemize:	$
Car(s)	$
Retirement Accounts (401(k), IRA profit sharing, pension, annuities, deferred comp arrangements, etc.)	$
Notes and Other Receivables	$
Tangible Personal Property (furnishings, jewelry, furs, antiques, and collectibles)	$
Other Please itemize with specific amount:	$
TOTAL ASSETS	

Liabilities	
Auto Loan(s)	$
Mortgage	$
Credit Card Debt	$
Other Debt *(includes child support, alimony, garnishments, IRS repayments, student loan repayment, other loans, etc.)*	$
Other Liabilities Not Included in Other Sections Please explain and itemize with specific amount:	$
TOTAL LIABILITIES	$