



Wish For A Smile Patient Application Form

Wish For A Smile is a non-profit charitable trust that relies solely on donations. The more information you can provide, the better we will be able to assess your needs. Wish for a Smile has a privacy policy that means this information will be confidential to the Trust and its professional advisers, and will not be available to anyone else. Applications are considered twice each year following the closing dates at the end of February and August. When the application is completed please post it to:

[Wish For A Smile, 3 Clyde Road, Riccarton, CHRISTCHURCH, 8041](#)

| | | | | |
|---|--|---|--------------------------------|---|
| First Name of Child: | | Last Name: | | DOB: dd/mm/yyyy |
| Address where child lives most of the time: | | | | |
| Street: | | | Suburb: | |
| Town/City: | | Region: | | Post Code: |
| Gender: | What is the child's immigration status (one box must be ticked to be eligible): | | | |
| <input type="checkbox"/> Male | <input type="checkbox"/> NZ Citizen (born in NZ) | | | |
| <input type="checkbox"/> Female | <input type="checkbox"/> NZ Citizen (born overseas) | | | |
| <input type="checkbox"/> Other | <input type="checkbox"/> NZ Permanent Resident | | | |
| What is the child's ethnicity: | | | | |
| <input type="checkbox"/> NZ European | <input type="checkbox"/> Māori | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Asian | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Other | <input type="checkbox"/> I'd prefer not to say | | | |
| Primary Parent / Caregiver - This will be the main contact person for the child's application | | | | |
| First Name: | | Last Name: | | |
| Relation to child: | | | | |
| <input type="checkbox"/> Same address where child lives most of the time | | | | |
| <input type="checkbox"/> Same address where child lives most of the time – if different please provide address: | | | | |
| Street: | | | Suburb: | |
| Town/City: | | Region: | | Post Code: |
| Home Phone Number: | | Mobile Phone Number: | | |
| Email Address: | | | | |

PART 1: ELIGIBILITY

I confirm that the Wish for a Smile applicant (all must be ticked to be eligible):

- Is 11-16 years of age
- Is keen to have orthodontic treatment, and will commit to looking after their braces, clean their teeth and attend all of their appointments (generally 5-8 weeks apart)
- Will commit to 20 hours of voluntary work within their community
- Has family/whānau/caregivers who will make a weekly financial donation to Wish for a Smile (a minimum of \$10 a week for 80 weeks (\$800))
- Has family/whānau/caregivers who are able to assist with transport to the orthodontic appointments if required

Please confirm one of the following (at least one must be ticked to be eligible):

- The child has at least one caregiver/parent who has a Community Services Card
(please provide details below)
- The child receives an Unsupported Child's Benefit
- The child receives an Orphan's Benefit

If applicable, please provide Community Services Card details:

Card Holder Name:

Card Number:

Expiry Date:

Please attach a photo of the front side of your Community Services Card

Has the applicant previously been assessed by an orthodontist Yes No

If Yes, please provide details:

Orthodontist Name:

Town/City

What contribution can you or your wider family/whānau make to treatment?

\$_____per week for 80 weeks (minimum \$10 per week for 80 weeks)

PART TWO: HOUSEHOLD INFORMATION

The Wish For A Smile Trust provides orthodontic treatment to young people with severe orthodontic problems from financially challenged families. To determine if you meet our criteria we require the following information:

Number of adults (over 18 years) in household _____

Number of children in household _____

Number of earners in household _____ (including WINZ benefits)

Do you receive an accommodation allowance Yes No If Yes, How much per week \$

NB: Please provide an IRD Personal Tax Summary for every income earner in the household

Earners 1:

Full name:

Income per week after tax:

Income is from (please circle as applicable)

Wages

WINZ benefit

Wages and WINZ benefit

Earners 2:

Full name:

Income per week after tax:

Income is from (please circle as applicable)

Wages

WINZ benefit

Wages and WINZ benefit

Earners 3:

Full name:

Income per week after tax:

Income is from (please circle as applicable)

Wages

WINZ benefit

Wages and WINZ benefit

Does anyone not living in the household financially contribute to the care of the child?

(i.e parent/caregiver at different address?) Yes No

If yes, please provide a Personal Tax Summary for this person:

Full name: Relationship to child:.....

Address:

Email:

Income per week after tax:

Income is from (please circle as applicable)

Wages

WINZ benefit

Wages and WINZ benefit

PART THREE: WEEKLY EXPENSES OF HOUSEHOLD (write \$0 if does not apply)

Accommodation /week \$ Rent Mortgage

PART FOUR: ASSETS OF HOUSEHOLD (write \$0 if does not apply)

1. Property:

2. Vehicles (over \$5000):

3. Other (family trusts, investments, etc):

OTHER INFORMATION

Some of our sponsors like to know who is receiving their goodwill. Please indicate below:
(*Selecting either does not affect your chances of acceptance*)

We are happy for the sponsors to know our identity We prefer to remain anonymous

Wish for a Smile is a charity and as such it seeks publicity in order to attract applicants and sponsors to ensure as many people as possible are able to receive treatment.

CONSENT

I/We understand that, as recipients of Wish For A Smile benefits, we may be required to take part in publicity activities for the Trust's website, its sponsors and/or for media activities. Please indicate below:

I/We agree/do not agree (please circle 'agree' or 'do not agree') _____ (child's name) will be available to participate in any publicity and/or media activities associated with Wish For A Smile Trust

(Please note: Willingness to or not to participate in publicity or media activities will not affect your application.)

I/we consent to allow for any information collected during this application process to be used **anonymously** (ie you and your child will not be identified) for auditing and research purposes

Should this application be successful:

- I/we accept that the orthodontic treatment will be carried out by the Trust's nominated Orthodontist.
- I/We consent to the Wish For A Smile Trust seeking dental information from my child's dentist/therapist
- I/We understand that additional dental or surgical treatment may be required to be undertaken by other health providers and there may be additional costs associated with this
- The above is a true and correct record of our financial position. I/We accept that if we provide misleading or false financial information we may be liable for the full (private) cost of orthodontic treatment, and any enforcement costs, including legal costs and expenses.
- I/We agree that we may be required to provide updated personal tax or WINZ summaries for each earner during the course of the orthodontic treatment

Signed _____ Date: _____

Name _____ Relationship to Child: _____

DECISIONS OF THE TRUST ARE FINAL. IF YOUR APPLICATION IS UNSUCCESSFUL PLEASE CONTACT YOUR LOCAL MEMBER OF THE NZAO WHO MAY BE ABLE TO ARRANGE A PAYMENT PLAN TO SUIT YOUR INDIVIDUAL NEEDS.

Application Check List --- make sure you have you attached all of the following:

- The Dental Assessment Form completed by your Dental Therapist/ Dentist
- The completed Patient Application Form
- A photograph of your Community Services Card
- A letter from you supporting your child's application
- A letter from your child supporting his/her application
- A letter from your child's school principal or Dean providing a character reference
- Six photos of your child and their teeth.
- A one page Inland Revenue Personal Tax summary (one for each income earner in household and anyone else contributing to the child's care)
- A self-addressed postage paid C4 (for A4) envelope