

**Relief Grant Program**  
**Application Check List for Applicants and Constituent Dental Societies**  
**Consistent with the ADAF Relief Grant Program Rules, Manual and Criteria**  
[www.adafoundation.org](http://www.adafoundation.org)

- Fill in all sections of the application.
- Double check calculations on pages 3-7 to ensure numbers entered and arithmetic are correct.
- Ensure all signatures and dates (page 8) are included.
- Verify (on page 8) that a personal interview has been conducted by the component and/or constituent society (face to face or telephone interview) to substantiate the application and supporting documentation.
- Include a current, original medical letter from physician/s, signed and dated. The letter should describe the disability(ies) and general health condition, including current treatment regimen required.
- If the applicant receives Social Security or other governmental/subsistence benefits, append a copy of the most current yearly statements received from the Social Security Administration entitled “*Your New Benefit Amount Statement*” plus a copy of the previous year’s Form SSA-1099-SM – “*Social Security Benefit Statement*” that provides benefits income information.
- Include verification that the applicant has sought and applied for all human service assistance to which he/she is entitled (e.g., transportation, meals, help with home energy costs, home care, and caregiver support services) before applying for the ADAF Relief Fund Grant. The local Area Agency on Aging (AAA) can provide case management services—search for a local AAA at the following Website: <http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx> or call 1-800-677-1116
- If applicant or deceased spouse served in the Armed Forces, include verification that the applicant has sought and applied for all Veteran’s Administration benefits to which he/she is entitled (e.g. surviving spouse pension and health care benefits). The Veteran’s Administration can provide case management services – search for a local/county VA site at [www.va.gov](http://www.va.gov) or call 1-800-827-1000.
- Income Taxes:
  - ✓ If the applicant does not file a federal income tax return, he/she must include a letter addressed to the ADA Foundation attesting to this fact, including applicant’s signature and date.
  - ✓ If the applicant files federal income tax returns (personal, business or both), copies of the most current signed and dated forms and all schedules must be submitted.
  - ✓ If taxes are electronically filed, include the appropriate IRS e-file form.
- Include supporting documentation for all liabilities and debts listed. Please include a letter of explanation for any special circumstance pertaining to the financial need, including as much detail as possible.
- A signed and dated IRS W-9 form must accompany new applications. Go to this website to download a W-9 form: <http://www.ada.org/applyforassistance.aspx>.

## APPLICATION FOR RELIEF GRANT

- A.  New Application (6-month installment)  
 Renewal (12-month installment)  
 Emergency (single installment)

**Eligibility for Grants.** Dentists, their dependents, and former dependents of deceased dentists are eligible to apply for financial aid from the ADA Foundation (sometimes hereinafter "ADAF" or "Foundation") if an accidental injury, advanced age, physically debilitating illness or medically-related condition prevents them from gainful employment and results in an inability to be wholly self-sustaining. Applicants are not required to be members of the American Dental Association or its constituent or component societies. No information shall be sought from applicants to ascertain their status as such a member or non-member, and no consideration shall be given to membership status in evaluating applications. Dependents are limited to a dentist's current spouse and blood-related or legally adopted children under the age of 18. A deceased dentist's spouse, if married at the time of the death, is also considered a dependent. If a deceased dentist's spouse remarries, he/she is no longer eligible for Relief grants.

**READ FIRST:** It shall be the duty of the recipient of the Relief Grant to notify the ADA Foundation within a reasonable time of any change of status in respect to his/her property or income. The ADA Foundation may, after verification, either suspend the assistance or vary the amount thereof in accordance with the circumstances; any excess assistance theretofore paid shall be returned to the American Dental Association Foundation. For a copy of the Relief Grant Rules, go to: [www.adafoundation.org](http://www.adafoundation.org).

The recipient has no property right or entitlement in the amount of the grant approved by the ADA Foundation. The setting of the amount of the grant is a settlement of intention only on the part of the Foundation. The Foundation may, at its total discretion, cease disbursement of the funds of the grant to any recipient, at any time.

### This Application Cannot be Processed Until it is Complete

(Fill in all sections of this application form.)

#### B. APPLICANT INFORMATION (Use typewriter or print clearly in black ink)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_ (O) \_\_\_\_\_  
Number & Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  Married  Single  Widower  Widow  Divorced  
Have you ever served in the Armed Forces?  Yes  No  
Are you eligible for veteran's benefits?  Yes  No If yes, date of application for veteran's benefits \_\_\_\_\_. Attach correspondence from Veteran's Administration regarding action on application to this form.  
Do you qualify for Social Security Payments?  Yes  No If Yes, Append a copy of the Form SSA-1099-SM "Social Security Benefit Statement" which provides benefits income information received from the previous year and form "Your New Benefit Amount Statement" which provides Social Security benefit income information you will receive for the current year.  
Have you been convicted of a Misdemeanor?  Yes  No If yes, please explain: \_\_\_\_\_  
Have you been convicted of a Felony?  Yes  No If yes, please explain: \_\_\_\_\_  
Have you filed bankruptcy?  Yes  No If yes, date: \_\_\_\_\_ Chapter 7 \_\_\_\_\_ Chapter 11 \_\_\_\_\_

#### C. DISABILITY AND EMPLOYMENT

Nature of disability \_\_\_\_\_

Date of onset of disability \_\_\_\_\_

Degree of disability:  Complete  Permanent  
 Partial  Temporary

Do you expect to practice dentistry again?  Not Applicable  Yes  No If yes,  Full Time  Part Time When? \_\_\_\_\_

Do you expect to pursue another occupation?  Not Applicable  Yes  No If yes,  Full Time  Part Time When? \_\_\_\_\_

**D. MEDICAL REPORT**

A current concise medical statement, including likelihood if/when applicant can return to work, signed and dated by a physician on the physician’s letterhead as to the medical condition including the type and degree of disability, chronic illness, diagnosis, prognosis and the medical care requirements of the applicant must be attached to this application whether the application is for an initial or renewal grant.

**E. DEPENDENTS AND NONDEPENDENTS**

Do you have any dependents?  Yes  No (NOTE: Dependents are defined in Rules Chapter I, Section A)

<u>Name of Dependents</u>	<u>Relationship to You</u>	<u>Age</u>	<u>Degree of Dependency (approx %)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are married, is spouse employed?  Yes  Full time  Part time  No

If no, is spouse able to obtain employment?  Yes  No (specify reason) \_\_\_\_\_

Please list all of your children, brothers, sisters and parents who are not listed under “Dependents” and provide the requested information for each one.

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Does This Person Live in Your Household?</u>	<u>Is This Person Able to Contribute To Your Support?</u>	<u>Indicate Amount Now Contributed Monthly</u>
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

Does anyone claim you as a dependent on a federal or state tax return?  Yes  No

If yes, please provide the requested information for each one.

<u>Name</u>	<u>Relationship</u>	<u>Degree of Support (approx. %)</u>	<u>Indicate Amount Now Contributed Monthly</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**F. VERIFICATION OF APPLICATION FOR AGENCY ON AGING ASSISTANCE**

Attach written documentation from the Area Agency on Aging, community or government agency showing you have sought and applied for all possible programs available, such as assistance with transportation, meals, food stamps, help with home energy costs, home care, and caregiver support services before applying for an ADA Foundation Relief Grant. See contact information attached to this application form. If eligible, documentation must list the assistance you are eligible for and receiving and if ineligible the reasons why you are ineligible. It is strongly encouraged that applicants talk with a case manager to ensure they have accessed all benefits to which they are entitled.

Name of Agency: \_\_\_\_\_ Name of Case Manager: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Case Manager’s Phone Number: \_\_\_\_\_

Programs You are Eligible to Receive Assistance for and amount:

Program (example, food stamps, energy assistance, etc.)	Monthly Amount	Yearly Amount
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

**G. TOTAL ANNUAL INCOME OF APPLICANT, SPOUSE OR DEPENDENTS – (Double check all calculations on this page.)**  
*(Be sure to answer each item – write “none” where applicable)*

	Received During Past Calendar Year	Expected During Current Calendar Year
Dental Practice: Gross Practice Income .....	1. \$ _____	1. \$ _____
Practice Expenses .....	2. \$ _____	2. \$ _____
Net Practice Income (Line G1 minus Line G2) .....	3. \$ _____	3. \$ _____
Other Occupation or Business Income .....	4. \$ _____	4. \$ _____
Retirement Distributions (IRA’s, Keogh, etc.) .....	5. \$ _____	5. \$ _____
Health and Accident Insurance Benefits .....	6. \$ _____	6. \$ _____
Disability Insurance Benefits .....	7. \$ _____	7. \$ _____
Social Security Benefits (SSD, SSI, OASI) .....	8. \$ _____	8. \$ _____
<b>(Attach Form SSA-1099-SM to verify Previous Year’s Social Security Income &amp; Form “Your New Benefits Statement” to verify Current Year’s Social Security Income.)</b>		
Veteran’s Compensation .....	9. \$ _____	9. \$ _____
Spouse’s Income .....	10. \$ _____	10. \$ _____
Interest and Dividends .....	11. \$ _____	11. \$ _____
Other Income (specify) .....	12. \$ _____	12. \$ _____
<b>Subtotal</b> (add Lines G3 – G12) .....	<b>13. \$ _____</b>	<b>13. \$ _____</b>

<b>For ADA Foundation to Complete Only – Do Not Complete</b>		
ADAF Relief Grant ( <input type="checkbox"/> 12 mos. <input type="checkbox"/> 6 mos. <input type="checkbox"/> One-time)..... Year _____ Year _____ Year _____	14. \$ _____	14. \$ _____ <b>(Applicant Please Leave Blank)</b>
<b>TOTAL INCOME</b> (ADA Foundation add Line G13 and Line G14).....	<b>15. \$ _____</b>	<b>15. \$ _____</b>

**ATTACH A SIGNED AND DATED COPY OF YOUR MOST RECENT PERSONAL AND BUSINESS (IF APPLICABLE) FEDERAL INCOME TAX RETURN WITH ALL SCHEDULES. IF YOU DO NOT FILE AN INCOME TAX RETURN, PLEASE SUBMIT A SIGNED WRITTEN STATEMENT ATTESTING TO THIS FACT.**

**H. TOTAL ANNUAL EXPENSES OF APPLICANT, SPOUSE OR DEPENDENTS – (Double check all calculations on this page.)**  
*(Be sure to answer each item – write “none” where applicable)*

Rental of House or Apartment .....	1. \$ _____
Home Maintenance (heat, utilities, etc.) .....	2. \$ _____
Mortgage Payments on Home .....	3. \$ _____
Real Estate Taxes .....	4. \$ _____
Food .....	5. \$ _____
Clothing .....	6. \$ _____
Health Care Not Covered by Insurance (itemize with Details, Use Separate Sheet of Paper) .....	7. \$ _____
Auto or Other Transportation .....	8. \$ _____
Income Tax Liability (Insert also on Page 7, Section P. Line 18) .....	9. \$ _____
Other Living Expenses (list each on a separate sheet) (See Page 5 for Directions) .....	10. \$ _____
<b>SUBTOTAL</b> .....	<b>11. \$ _____</b>

<u>Insurance Policies (List and Itemize All Insurances)</u>	<u>Amount of Policy</u>	<u>Annual Premium</u>
Health, such as Blue Cross /Blue Shield .....		12. \$ _____
Hospital Indemnity/Critical Coverage .....		13. \$ _____
Homeowners/Renters .....		14. \$ _____
Disability Income Protection .....	\$ _____	15. \$ _____
Accidental Death and Dismemberment .....	\$ _____	16. \$ _____
Life .....	\$ _____	17. \$ _____
Burial .....	\$ _____	18. \$ _____
Auto .....	\$ _____	19. \$ _____
Other (List and Itemize All Insurances, Use Separate Sheet of Paper) _____	\$ _____	20. \$ _____
Total Annual Premiums (add Lines H12 – H20) .....		21. \$ _____
<b>TOTAL EXPENSES</b> (add Lines H11 and Line H21) .....		22. \$ _____

**NOTE: The following expenses are not considered by the ADA Foundation to be basic living expenses and may not be included on Page 4, Section H, Other Living Expenses, Line 10:**

- Cell phone (unless it is the individual's or family's only telephone)
- Cable television, other than basic cable
- Internet service
- Pet food or supplies
- Donations to church or other charity
- Home services (such as gardener, landscaping, pool service)
- Membership fees to health clubs, AARP, etc.
- Outstanding income taxes or other liabilities (list liabilities on Page 7, Section P, Lines 18 and 20-24)
- Private school tuition and fees for dependents under the age of 18
- Auto payments for a second vehicle
- Recreational vehicles (such as a boat, plane, jet ski, snowmobile, etc.)
- Expenses related to a second home or vacation home
- Any form of private lessons for applicant or dependent children (such as musical instruments, sports, exercise classes, etc.)
- Summer or Day Camp expenses for dependent children
- Vacation expenses
- Personal entertainment, dining out, movies, theater, plays, etc.
- Family gifts for holidays or birthdays (Christmas, etc.)
- Subscriptions for magazines, movies, etc.
- Other discretionary expenses

**I. BANK, S&L AND CREDIT UNION ACCOUNTS – (Double check all calculations on this page.)**

(List bank accounts, certificates of deposit, money market accounts and saving accounts. If additional space is needed, please copy or Download another worksheet.)

1. Name and Location of Bank	2. Type of Account	3. Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

**J. REAL ESTATE**

The legal and equitable title to all real estate listed in this statement is solely in the name of the undersigned, except as follows:

1. Description	2. Outstanding Mortgages or Liens	3. Monthly Payment	4. Assessed Value	5. Est. Fair Mkt. Value	If applicable, unpaid taxes:	
					6. Year	7. Amount
_____	\$ _____	\$ _____	\$ _____	\$ _____	_____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	_____	\$ _____

**K. OTHER LOANS (include credit card debt)**

1. Loan Held By (Name and Address)	2. Amount Of Loan	3. Amount Owing	4. Pay Off Date	5. How Endorsed Guaranteed or Secured
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____

**L. ACCOUNTS RECEIVABLE**

(List the largest amounts owing to applicant and spouse)

Name and Address of Debtor	1. Amount Owing	2. Date Payment Expected
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

**M. LIFE INSURANCE**

1. Name of Insured	2. Name of Beneficiary	3. Name of Insurance Co.	4. Type of Policy	5. Face Amount of Policy	6. Total Cash Surrender Value	7. Total Loans Against Policy	8. Is Policy Assigned?
_____	_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	_____	\$ _____	\$ _____	\$ _____	_____

**N. STOCKS, BONDS AND SECURITIES OF ANY TYPE**

1. Face Value (Bonds) No. of Shares (Stocks)	2. Description Of Security	3. Present Market Value	4. Income Received Last Year	5. To Whom Pledged
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____

**O. RETIREMENT PLANS**

(List any IRAs, 401(k), Keogh plans, profit-sharing or pension plans.)

1. Type	2. Most Recent Valuation	3. Date of Valuation
_____	_____	_____
_____	_____	_____

**P. ASSETS AND LIABILITIES – (Double check all calculations on this page.)**

(Please answer all questions using "No" or "None" where necessary. Use totals from Sections H-O where applicable.)

Include supporting documentation for all liabilities and debts listed. Please include a letter of explanation for any special circumstance pertaining to the financial need, including as much detail as possible.

**ASSETS**

(wholly or jointly owned by dentist or spouse) \_\_\_\_\_

- 1. **Cash** (Total Section I.3) \$ \_\_\_\_\_
- 2. **Real Estate** (Total Section J.5) \$ \_\_\_\_\_
- 3. **Accounts Receivable** (Total Section L.1) \$ \_\_\_\_\_
- 4. **Life Insurance, Cash Surrender Value** (Total Section M.6 – Do not deduct loans) \$ \_\_\_\_\_
- 5. **Stock and Securities** (Total Section N.3) \$ \_\_\_\_\_
- 6. **Retirement Plans** (Total Section O.2) \$ \_\_\_\_\_
- 7. **Dental Practice** (including equipment) \$ \_\_\_\_\_
- 8. **Vehicle(s), Year, Make and Model and Estimated Value:**  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_
- 9. **Other Assets** (itemize) \$ \_\_\_\_\_
- 10. \_\_\_\_\_ \$ \_\_\_\_\_
- 11. \_\_\_\_\_ \$ \_\_\_\_\_
- 12. \_\_\_\_\_ \$ \_\_\_\_\_
- 13. **Total Assets** (Add P.1-P.12) \$ \_\_\_\_\_

**LIABILITIES AND NET WORTH**

(wholly or jointly owned by dentist or spouse) \_\_\_\_\_

- 14. **Other Loans** \$ \_\_\_\_\_  
(Total Section K.3 – Direct borrowing only)
- 15. **Loans Against Life Insurance** \$ \_\_\_\_\_  
(Total Section M.7)
- 16. **Accounts Payable** \$ \_\_\_\_\_
- 17. **Real Estate Taxes Payable** (Total Section J.7) \$ \_\_\_\_\_
- 18. **Income Tax Payable** (Total Section H.9) \$ \_\_\_\_\_
- 19. **Outstanding Mortgages or Liens** (Total Section J.2) \$ \_\_\_\_\_
- 20. **Other Liabilities** (itemize) \$ \_\_\_\_\_
- 21. \_\_\_\_\_ \$ \_\_\_\_\_
- 22. \_\_\_\_\_ \$ \_\_\_\_\_
- 23. \_\_\_\_\_ \$ \_\_\_\_\_
- 24. \_\_\_\_\_ \$ \_\_\_\_\_
- 25. **Total Liabilities** (Add Lines P.14-P.24) \$ \_\_\_\_\_
- 26. **Net Worth** (Line P.13 minus Line P.25) \$ \_\_\_\_\_
- 27. **Total Liabilities and Net Worth** (Add Line P.25 plus Line P.26) \$ \_\_\_\_\_

**(Double check that all signatures are affixed on this page.)**

**Q.** I have no assets or resources other than those disclosed in this application. I hereby authorize any person, firm corporation, agency or institution to furnish the American Dental Association Foundation any and all information in its possession relative to my assets, deposits, dealings or business of any kind whatsoever, or concerning any matter affecting this application which the American Dental Association Foundation may desire.

**CONSENT**

The undersigned hereby consents to disclosure of Confidential Information (as hereinafter defined) to the **ADA Foundation and within the tripartite of the American Dental Association** in connection with the review and processing of the undersigned's Relief Grant application, and any follow-up, administration, or renewal thereof. Each of the tripartite and **ADAF** has the right to inspect and copy such Confidential Information. Refusal to sign this Consent may result in rejection of any Relief Grant. This Consent expires on the date which any grant made would expire and may be revoked at anytime prior thereto. As used herein, "Confidential Information" means any financial or medical information or records, and any information and records provided to **ADAF** in connection with mental health or developmental disability services provided to the undersigned.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, (Year) \_\_\_\_\_

Applicant Signature: \_\_\_\_\_  
(Application must be signed by Applicant or Power of Attorney, with attachment copy of POA)

Witness Signature: \_\_\_\_\_  
(Witness signature is required under the Illinois mental health and developmental disabilities confidentiality act)

**If this application is approved, please make grant checks payable to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_  
(if other than applicant)

**This Section to Be Completed by Component and/or Constituent Society Verifiers**

I personally interviewed the applicant face to face \_\_\_ or by phone \_\_\_ and verified all the information contained in this application to be complete and accurate.  
(check one)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(component society verifier designee)

And/Or

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(constituent society verifier)

**Agreement to Participate in Grant**

This is to certify that \_\_\_\_\_ and \_\_\_\_\_  
(component society) (constituent society)

- Recommend a:  New grant (6- month installments)  
 Renewal grant (12-month installments)  
 Emergency (single installment)

to: \_\_\_\_\_ in the sum of \$ \_\_\_\_\_  
(total aid requested)

and will pay the ADA Foundation the sum of \$ \_\_\_\_\_ in \_\_\_\_\_ monthly installments of \$ \_\_\_\_\_ each.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(executive director, component society)

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(executive director, constituent society)

**For ADA Foundation use only**

Grant No: \_\_\_\_\_ Month and Year of First Grant \_\_\_\_\_

Month and Year Current Grant Expires \_\_\_\_\_

# The Aging Network

To meet the diverse needs of the growing numbers of older persons in the United States, the Older Americans Act of 1965 (OAA) created the primary vehicle for organizing, coordinating and providing community-based services and opportunities for older Americans and their families. All individuals 60 years of age and older are eligible for services under the OAA, although priority attention is given to those who are in greatest need.

The OAA established a national network of federal, state, and local agencies to plan and provide services that enable older adults to live independently in their homes and community. This interconnected structure of agencies is known as the National Aging Network.

The National Aging Network is headed by the U.S. Administration on Aging. The network includes 56 State Agencies on Aging, 629 Area Agencies on Aging, 246 Native American aging programs, over 29,000 service providers, and thousands of volunteers.

Contact information for all services is listed below.



General Contact Information: 1-800-677-1116

<http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>

- [State Units on Aging](#)
- [Area Agencies on Aging](#)
- [Aging and Disability Resource Centers](#)
- [Services Available](#)

## ADA FOUNDATION

### Fifteen Most Referenced Rules

Excerpted from:

**Relief Grant Program  
Rules, Manual and Criteria**

#### **Including Explanatory Intent Statements**

#### Chapter I: Relief Grants

##### Page 1, A. Eligibility for Grants

Statement from *Rules*: “Dentists, their dependents and former dependents of deceased dentists are eligible to apply for financial aid from the ADA Foundation if an accidental injury, advanced age; physically debilitating illness or medically-related condition prevents them from gainful employment and results in an inability to be wholly self-sustaining.”

Intent: Relief grants are intended to assist applicants who because of illness or disability are unable to earn income sufficient to meet daily living expenses. Daily living expenses are explained on the application form.

Statement from *Rules*: Dependents are limited to a dentist’s current spouse and blood-related or legally adopted children under the age of 18. A deceased dentist’s spouse, if married at the time of death, is also considered a dependent. If a deceased dentist’s spouse remarries, he/she is no longer eligible for Relief grants.

Intent: The definition of a dependent is a wife or husband and blood related children or legally adopted children under 18 years old. A wife/husband of a dentist who has died while married is a dependent. If this dependent remarries, this person no longer qualifies for a Relief grant.

##### Page 1, B. Policy on Awarding Grants

Statement from *Rules*: It is the policy of the ADA Foundation discretionally to award relief grants for meeting emergency needs and daily living expenses rather than for pensions or annuities or to conserve resources or assets. The awarding of a grant shall not be deemed a right or an entitlement to the applicant for a grant.

Intent: The ADA Foundation uses good judgment to give relief grants to pay emergency needs and daily living expenses. Relief grants are not given to be used as retirement income or to help an individual conserve cash savings or other investments. A Relief Grant is a gift, it is not an entitlement.

##### Page 1, C. Amount of Grant

Statement from *Rules*: The amount of any grant shall be determined by the Committee after recommendation by the society or societies originating the application. In determining the amount of the grant, the Committee will take into consideration the particular circumstances of each applicant, including financial needs, age and physical conditions, opportunity for assistance from immediate members of the family, financial assets and all other relevant factors.

Intent: Final decisions on all grant amounts take into consideration the constituent/component society recommendation. In making this decision the Committee will consider the applicants current situation, financial need, age and medical disability. To facilitate fiscal responsibility and due diligence, the Committee and the Board may ask for additional information at any time, including requesting that local Aging services be sought.

## Page 1, D. Form and Duration of Grants

Statement from *Rules*: The duration of an individual grant is determined by the Committee but an initial grant may not exceed six months. Any subsequent extensions may be made for periods not to exceed twelve months. If an emergency grant, as described below, is given, it may be made only once to an individual, unless the Board approves the payment of said additional emergency grant upon a finding the extraordinary circumstances exist.

Intent: The Committee will approve a first time grant only for six months. Any renewal grants will be approved up to and no more than twelve months. An emergency grant can only be approved and given one time, unless extraordinary circumstances exist.

## Page 2, D. Form and Duration of Grants

Statement from *Rules*: The recipient has no property right or entitlement in the amount of the approved grant. The setting of the amount of the grant is a statement of intention only on the part of the ADA Foundation. The ADA Foundation may, at its total discretion, cease disbursement of the funds of the grant to any recipient, at any time.

Intent: The ADA Foundation and Committee approve and agree to the amount of the grant award. The Foundation at any time can choose to stop payment of this grant to the relief grantee.

## Page 2, F. Emergency Grants

Statement from *Rules*: An emergency grant is the payment of assistance in a single installment, which may be made by the ADA Foundation Relief Grant Program on its own motion or on the approval of a request from a constituent society relief fund. Emergency grants will be made only in cases of special emergency as determined by the Committee after a full explanation of all pertinent circumstances. These include but are not limited to situations or occurrences of a serious nature, developing suddenly and unexpectedly, and demanding immediate attention, e.g., eviction from living space; foreclosure on dwelling; sudden illness with no medical insurance; sudden death with no financial resources for remaining spouse; no financial resources for food, clothing and shelter. The amount of an emergency grant shall be determined by the Committee after recommendation of the constituent society relief fund involved. Constituent and component societies commit themselves to joint payment of one-half of any grant, which is made by the ADA Foundation Relief Grant Program upon making a request for the emergency grant. An application form shall be completed for every recipient of an emergency grant.

Intent: The one-time-only emergency grant is paid in one payment. A relief application must be filled out for the Committee to consider an emergency grant. The constituent dental society will request the amount of the emergency grant and the Committee will make the final decision on the grant amount when approved.

Statement from *Rules*: An application for a grant must be processed initially by the component society where an applicant practices, then with the constituent society relief fund. If no component society exists, the application is initially processed by the constituent society relief fund. An applicant who does not practice within the jurisdiction of a constituent or component dental society may forward his or her application directly to the ADA Foundation. When an applicant has resided in more than one constituent society, application shall be made through the relief fund of the constituent society under whose jurisdiction he or she is currently practicing or practiced last. There shall be no objection, however, to an agreement, which will permit two constituent society relief funds to participate in a grant on a pro rata basis related to years of practice under each jurisdiction. If the constituent society where the applicant is practicing or practiced last does not wish to participate; the applicant may apply with a constituent society where he or she once practiced or with the constituent society where he or she currently resides.

Intent: Applications for a relief grant begin at the local and state dental society where the applicant last practiced dentistry. The rationale is that dentist provided dental care to the public in that state, therefore, the state provides help to the dentist in need who practiced in that state. If there is no state society Relief Grant Program where the dentist practiced this individual can make a grant request directly to the ADA Foundation.

If a dentist practiced in more than one state, he/she would apply for relief through the most current state of practice or where practiced last. There is no reason two states cannot participate in a grant for one individual. The payment from each state can be determined by the number of years of practice in each state.

If a state society where the applicant practiced last does not agree to participate in paying toward a grant, the applicant can apply to the state where he/she previously practiced or where he/she currently lives.

Statement from *Rules*: All requests for grants must be made on the application form approved by the ADA Foundation. All questions on the application form must be answered carefully and comprehensively by the applicant or his or her sponsor. All information received in connection with an application for assistance will be regarded as confidential. No grants will be made on the basis of an incomplete application except in the discretion of the Committee where an emergency grant is sought. In such emergency cases, the application must be made complete as expeditiously as possible.

Intent: When asking for a relief grant, applicants must fill out the official relief grant application form provided by the ADA Foundation. An application must be completely filled out or it will be returned to the constituent society. All information on the form is confidential.

Statement from *Rules*: Emergency and initial grants may be pre-funded by the constituent society relief fund. Upon an approval of the grant by the Committee, the constituent society relief fund will be reimbursed by the ADA Foundation for its share of the grant. However, such pre-funding by a constituent society relief fund does not obligate the ADA Foundation to participate. In the event that the Committee does not approve the grant the constituent society relief fund that has provided the grant shall be responsible for the grant amount, and, if the grant is reduced by the Committee, the ADA Foundation will provide its share based upon the amount approved by the Committee.

Intent: A state dental society can pay for a grant amount directly to an applicant before the ADAF has approved such a grant. When the grant is approved by the ADAF, ADAF will repay the state dental society for its share of that grant. If the ADAF doesn't approve the grant, no repayment will be made to the state dental society. If the grant is approved at a lesser amount, the ADAF will repay the state back its portion of the lesser amount for that grant. The state society will then be responsible for that additional portion over the approved grant amount.

Page 6, Requirements for Determine Eligibility for Relief Grants, #1.

Statement from *Rules*: The primary purpose of the American Dental Association Foundation Relief Grant Program is to provide aid of an emergency and temporary character to dentists and, when individual circumstances demonstrate unusual need and the resources of the ADA Foundation Relief Grant Program permit, to deserving dependents of dentists.

Intent: The purpose of giving a relief grant is for emergency and temporary reasons to help dentists when something happens and that dentist cannot meet daily living expenses. If there are enough funds and good reasons the ADAF Relief Grant Program can give a grant to deserving dependents of a dentist.

Page 7, Requirements for Determining Eligibility for Relief Grants, Application Form: #1.

Statement from *Rules*: Service in the Armed Forces. If the applicant has a record of active service in the armed forces at any time, the applicant may be entitled to certain benefits from the Veterans Administration. The applicant or member of the family should be advised about making inquiry to the proper agency for veterans' affairs.

Intent: As part of the application verification, societies should determine whether an applicant is a veteran or a deceased spouse was a veteran. The applicant should seek benefits through the local Veterans Administration. Possible benefits may include survivor's pension and medical benefits.

Page 8, Requirements for Determine Eligibility for Relief Grants, Application Form: #12.

Statement from *Rules*: Report of Component and Constituent Society Relief Fund Verifiers. It is desirable to have representatives of both the component society (where applicable) and constituent society relief fund participate in the interviews required for each grant request and make a joint report. In such instances both verifiers should sign the report. It may not always be possible to have both levels represented, but in all cases a member of either the constituent society relief fund or the component society make the verification and submit the report. No approval shall be given without at least one personal interview with the applicant or in appropriate circumstances his or her guardian.

Intent: A personal verification must be completed by the local and/or state society to facilitate fiscal responsibility and due diligence on the application and request will not be considered for a grant. A member or representative of either the societies must conduct a verification of the application by providing a report or by completing and signing the relief grant application.

Page 8, Requirements for Determining Eligibility for Relief Grants, Application Form: #13.

Statement from *Rules*: Medical Report. The applicant's physician should provide a concise medical statement as to the condition of the applicant including the degree of disability, diagnosis, prognosis, and type of care needed. The statement is required whether the application is for an initial or renewal grant.

Intent: The application cannot be processed without a current medical report. The physician's medical report must provide the applicant's disability and medical condition with the degree of disability and form of treatment.

Page 10, Criteria for Relief Grants, #2.

Statement from *Rules*: It is not the purpose of the ADA Foundation Relief Grant Program to provide continuing assistance when the beneficiary is eligible for, or receiving, satisfactory aid from local, state or federal agencies.

Intent: The ADA Foundation Relief Grant Program provides continued financial assistance after an applicant receives assistance from a local aging or human services agency. Examples of assistance an applicant may qualify for include: food stamps, utility bill payment assistance, home repairs, house cleaning, meals on wheels or transportation