The Charles L. and Dorothy Weaver Memorial Orthodontic Grant
Community Foundation of the Ozarks
APPLICATION DEADLINE: MARCH 31, 2025

The Charles L and Dorothy Weaver Memorial Orthodontic Grant Program provides three scholarships annually for full treatment orthodontic services for individuals who meet the following criteria:

- ❑ Applicant must be within the age range of 10 to 30 years of age, with a full set of permanent teeth already in place.
- ❑ Applicant must be within the service area of the Community Foundation of the Ozarks (southern Missouri Ozarks region).
- ❑ Applicant must be within driving range of and the ability to travel to the participating orthodontist's offices in the Springfield Metro Area for the full 20 to 30+ month timeline for optimum treatment outcomes and must have a means of transportation to orthodontic appointments through a parent or guardian or have the ability to self-transport.
- ❑ Applicants must have access to a general dentist who will continue to provide cleaning and maintenance requirements during the span of treatment by the orthodontist.
- ❑ Financial need of applicant must be established through eligibility for participation in the Federal Free Lunch program through the school they attend or, if not in school, proof of qualification for Medicaid.

All fields of this application are required.
For questions, contact Ashley Fleming at (417) 864-6199 or afleming@cfozarks.org.

CANDIDATE INFORMATION

Candidate Name _____

Date of Birth _____ Age _____

Home Address_____

City _____ State _____ Zip_____

School _____ School Nurse Name_____

Dentist_____Dentist Phone_____

GUARDIAN INFORMATION (APPLICANTS UNDER 18 YEARS OF AGE)

Parent/ Legal Guardian_____

Permanent Phone_____ Cell Phone_____ Email_____

Address (if different from above) _____

If not parent, relationship of guardian to candidate_____

WEAVER APPLICANT ESSAY

Attach a one page letter answering the following question: if selected, how will the Weaver grant impact your life? Additionally, please confirm a commitment to attend all required appointments and follow all guidelines set by the orthodontist during treatment.

LETTER OF RECOMMENDATION

Attach a one-page letter of recommendation from a non-family member which outlines the character of the applicant.

APPLICATION CHECKLIST

Your completed Weaver orthodontic application must include the following in the order listed:

- ❑ Weaver Application (above)
- ❑ Parent/Legal Guardian Agreement Form
- ❑ School Nurse Recommendation Form
- ❑ Dentist Recommendation Form
- ❑ One-page letter of recommendation from a non-relative
- ❑ Applicant's one-page essay

CERTIFICATION

To the best of my knowledge, I certify that all information on this form is true and complete.

_____ _____

Applicant Signature Date

If applicant is under 18 years of age, the parent/legal guardian must also sign to verify.

_____ _____

Parent/Legal Guardian Signature Date

DEADLINE: March 31, 2025

Mail completed application to:
Community Foundation of the Ozarks - Attn: Ashley Fleming
PO Box 8960, Springfield, MO 65801
For questions regarding this application, call (417) 864-6199 or email afleming@cfozarks.org.

Screening of Weaver applicants will take place during summer 2025. Applicants will be notified of acceptance/denial in fall 2025.

The Charles L. and Dorothy Weaver Memorial Orthodontic Grant
Parent/Legal Guardian Agreement Form

Please complete this agreement form is applicant is under 18 years of age.

PARENT/LEGAL GUARDIAN STATEMENT OF AGREEMENT

I understand that if my child is chosen for orthodontic treatment s/he can be expected to be at the orthodontist's office monthly over the course of at least two years. I agree to provide transportation for my child to the orthodontist in order to insure quality care for the period of time necessary to complete care. I understand that if my child does not keep appointments with the orthodontist, s/he will lose this grant for braces and the orthodontist will cease treatment.

I agree to the transportation criteria stated above as well as the following:

- ❑ I will continue to provide transportation if change of residence occurs during the projected term of the orthodontia.
- ❑ I will assist my child in learning and practicing good oral hygiene.
- ❑ I will assist my child in following treatment requirements.

_____ _____

Parent/Legal Guardian Signature Date

If someone other than the parent/legal guardian listed above will be partially or completely responsible for the transportation of the applicant during administration of orthodontic treatment, please confirm commitment by completing the following information:

Transportation Assistance Provided by (Name)_____

Permanent Phone_____ Cell Phone_____

Address (if different from above) _____

I commit to assisting the applicant in attending scheduled appointments.

_____ _____

Transportation Provider Signature Date

The Charles L. and Dorothy Weaver Memorial Orthodontic Grant
Dentist Recommendation Form

This form is to be completed by the candidate's dentist. Please complete the following information to the best of your ability based on your knowledge of the candidate.

Candidate's name _____

Dental Office Providing this Recommendation_____

Dentist Name_____Phone_____

Candidate's Parent/Guardian (if under 18 years of age)_____

DENTAL CRITERIA

Please note: Applicants with true skeletal Class III or severely impacted teeth (specifically cuspids) cannot be considered for a Weaver Orthodontic grant due to the program's funding structure.

Please check one or more:

- ❑ Applicant is 10 years of age – 30 years of age (required)
- ❑ Applicant has a full set of permanent teeth (required)
- ❑ Misaligned teeth affecting speech
- ❑ Misaligned teeth affecting nutrition
- ❑ Misaligned teeth causing facial disfiguration
- ❑ Misaligned teeth, causing temporomandibular joint problems

Is this candidate reliable in terms of appointment keeping? ❑ Yes ❑ No

Does this candidate comply with dental instructions? ❑ Yes ❑ No

How many times has this patient visited your office and how many years? _____

Describe the orthodontic need:

_____ _____

Dentist Signature Date

The Charles L. and Dorothy Weaver Memorial Orthodontic Grant
School and School Nurse Recommendation Form

Complete this form is candidate is in attendance at public school. If candidate is not in attendance at public school, proof of qualification for Medicaid must be provided with application. Please complete the following information to the best of your ability based on your knowledge of the candidate.

Candidate's Name _____

School in which Candidate attends_____

School Nurse Name_____Phone_____

School Principal Name_____Phone_____

Candidate's Parent/Guardian_____

QUALIFICATION FOR FINANCIAL NEED

Applicants to the Weaver Program must be of financial need, established by either participation in the federal free lunch program or by qualification for Medicaid.

I certify this candidate is of financial need and can confirm the following (check all that apply):

- ❑ Participation in the Federal Free Lunch Program
- ❑ Qualification for Medicaid

CANDIDATE ASSURANCES

Is this candidate currently enrolled at your school? ❑ Yes ❑ No

Date of enrollment at current school_____
Date of enrollment at previous school (if applicable)_____

Will this candidate be able to follow directions given by orthodontist? ❑ Yes ❑ No

SCHOOL NURSE OR PRINCIPAL CONFIRMATION

I confirm the information listed above and believe this student is a quality candidate for the Weaver Orthodontic Program.

_____ _____
School Nurse or Principal Signature Date