Application for Sponsorship

South Dakota Eastern Star Assisting Children to Smile (ACTS) Program In Association with the South Dakota Dental Foundation Sunshyne Smiles Program

(to be completed by parent/guardian)

Child's Name:____

(First) (MI) (Last)

Birthdate: ______________________________________ Sex: ____ Male ____ Female

Parent/Guardian Name (s):____

(First) (MI) (Last)

Address: __________________________________ Daytime Phone: __________________

City/State/Zip: ______________________________ Other Phone: __________________

E-mail Address:____

Number of members in your household Adults: __________ Children: _________

Are Parents/Guardians employed? Father Yes/No

Mother Yes/No

Total Monthly Net Income $_________

Total Monthly Expenses $_________

Yearly family income for past two years Year: ________ $_________

(Please attach copies of IRS Form 1040) Year: ________ $_________

Does your child/family receive Food Stamps? Yes No

Does your child/family receive free or reduced school lunch? Yes No

Does your family receive housing assistance? Yes No

List amount of liabilities:

Mortgage $ _________

Loans $ _________

Credit cards $ _________

Other debt $ _________

List value of assets:

House $_________

Investments $_________

Land/Real estate $_________

Savings $_________

Other $_________

Describe any extra ordinary circumstances affecting your child or your family:

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Return application to:
South Dakota Dental Foundation
Order of the Eastern Star
PO Box 1194
Pierre SD 57501

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(to be completed by child)

Name: ____

My Parents/Guardian: ____

I live at: ____

____

I go to school at: ____

My Siblings and their ages: _________________________________ _____________________

_________________________________ _____________________

_________________________________ _____________________

My dentist's name: ____

I would like to have orthodontics/braces because: ____

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Sincerely,

Name: ____