Application for Relief Fund Assistance for Dentists

Date: _____

Applicant Information

Name: _____

Applicant must be a <u>dentist, spouse of a dentist, or dependent of a dentist</u> (under the age of 18 to be eligible for this grant.)

Current address: _____

City: _____ State: _____ ZIP code: _____

Primary phone: _____ Cell phone: _____ E-mail address: _____

Date of birth: _____ Marital status: _____

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

State where the dentist practice(d): _____

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

Employment Status

Current employer:_____

Month/year began:_____

Provide additional details about employment below:

Description of Emergency and/or Hardship

To help the TDA Relief Fund better understand your circumstances, please provide answers to the following questions.
Provide any backup documentation to your responses as attachments.

1. What specific life circumstance has precipitated your financial need, and when did it occur? Provide as many details as possible. Feel free to write on a separate piece of paper and attach to your application.

2. Have you 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 of support for these resources)

☐ Yes ☐ No If yes, what benefits have you used or do you plan to use?

3. What other outside sources of support are available to you?
(examples include but are not limited to family, community resources, Department of Aging, VA benefits, etc.)
(attach any documentation of support for these resources)

4. Have you or another household member previously requested assistance from the TDA Relief Fund?
☐ Yes ☐ No If so, when *(month/year)*?

Acknowledgement

By signing below, I represent and acknowledge that the above information is accurate and true to the best of my knowledge and has been provided in conjunction with my application for charitable assistance from the ADA Foundation. In addition, I acknowledge that this information may be shared with a third party including but not limited to the ADA Health and Wellness Division.

Print Name:_____

Signature:_____

Date:_____