Thank you for expressing your interest in the Prosthodontics Intermedica Foundation. We want to assure you that your dental needs are important to us and that we do our best to process and treat as many worthy candidates annually as we possibly can.

The PI Foundation is a fully charitable organization, publicly and privately funded, and serviced by skilled and experienced administrators and clinicians who lovingly donate their time and talent to enrich the lives of others. As such, it is very important to us that we have adequate personal information in order to determine patient selection for our life-changing grants.

In order to qualify, Foundation treatment candidates must return by mail the enclosed comprehensively completed application, along with copies of the first two pages of their federal income tax return for the past two years. Independently, we must also receive two letters of recommendation from individuals who can attest that both the dental and economic situations of the potential candidate are needy.

Every application will be considered. While we do not have a department that can monitor the status of each candidate, completed applications remain alive in our system until the candidate has either been invited for treatment or has received a letter indicating disqualification.

Please understand that we receive many more applications than we can possibly bring into our dental center for care. It is our policy to meet the most critical needs for persons of high integrity. Be assured that all personal patient information is carefully safeguarded within the Foundation.

Sincerely,

Joanne M. Balshi, Trustee

PS: Please make a copy of your application and other contents of the Foundation packet for your records. Please mail your package to us. Do not fax it.

PPS: Family members of former Foundation recipients are not eligible.

PPPS: Please do not telephone or email Pi Dental Center. All inquiries pertaining to the Foundation should be made via postal mail.

Prosthodontics Intermedica Foundation • 467 Pennsylvania Avenue, Suite 201, Fort Washington, PA 19034 • (215) 646-6334 • Fax (215) 643-1149

APPLICATION

Prosthodontics Intermedica Foundation

Patient Care Grants

PLEASE FILL IN ALL INFORMATION

Name Email Address:_____

_____

Last First Middle Initial

Address (No box numbers please):_____

City:_____ State:_____ Zip:_____ Telephone: (_____)_____

Marital Status: Married [ ] Divorced [ ] Single [ ]
Separated [ ] Widowed [ ] Engaged [ ]

GENDER: Male___ FEMALE___

Social Security Number _____ Birthdate _____
(mo) (day) (yr)

Employer
_____ Occupation _____

Address Bus. Phone (____)_____
_____
_____

Guarantor _____

Length of Time Working for Present Employer:_____

Name of Spouse:_____
Last First Middle Initial

Spouse's Employer Occupation _____
_____ Bus. Phone (____)_____

Address
_____
_____

Length of Time Spouse Has Worked for Present Employer:_____

Driver's License #:_____ Date of Birth:_____

Names of Dependents:
_____ _____

_____ _____

_____Initial Here

Prosthodontics Intermedica Foundation
Patient Care Grants (Continues)

Closest Family Member not living with you (include address): _____

_____ Telephone: (_____)_____

Your Yearly Income:_____ Combined Household Income:_____

Please describe your present dental condition:

_____

_____

_____

_____

_____

_____

Please describe any medical conditions that are related to your present dental condition:

_____

_____

_____

_____

_____

_____

Please describe the reason or cause of your present dental condition:

_____

_____

_____

_____

Please describe how you would like The Prosthodontics Intermedica Foundation to help you:

_____

_____

_____

_____

_____Initial Here

Prosthodontics Intermedica Foundation
Patient Care Grants (Continues)

Please describe your present financial situation and why you feel that you should be considered for assistance (Please attach your last 2 years W-2 forms):

_____

_____

_____

_____

_____

_____

Please describe what assistance, if any, is available from family or friends:

_____

_____

_____

_____

_____

_____

Do you have medical insurance? [__] Yes [__] No
Company: _____ Under who's name is the policy? _____

If you are selected for care, can you contribute to your treatment? [__] Yes[__] No

If so, how much could you contribute? _____

If a patient care grant was provided for you, would you allow Prosthodontics Intermedica to use your photos and description of treatment to aid in public awareness of dental implants and the mission of the Foundation?

[__] Yes [__] No

I agree to waive any and all legal rights, which may arise as a result of charitable treatment I may receive from a Prosthodontics Intermedica Foundation patient care grant.

_____ _____
Signature Date

I attest that all information provided above in this application is accurate to the best of my knowledge. I understand that any false statement or misrepresentations will make me ineligible for consideration for a patient care grant.

_____ _____
Signature Date

_____Initial Here