

**DISTRICT OF COLUMBIA DENTAL SOCIETY FOUNDATION
GRANT APPLICATION FORM**

(Please type or print)

Name of Organization _____

Name of Contact _____ **Title** _____

Address _____

Telephone _____ **Fax** _____

E-mail _____

In the space below, provide a brief description of your organization.

Briefly describe how the grant funds would be utilized.

Description of Population Served.

Dental Program Specific Information.

Annual Dental Budget \$ _____

Number of Patients Treated Annually _____

Number of Volunteer Dentists Participating _____

**Number of Dentists Receiving Compensation
(Paid Staff Dentists)** _____

Annual Treatment Provided in Dollars \$ _____

List the Ten Most Common Types of Treatment Performed

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient's Clinical Expenses - Are Patient's Clinical Expenses Reimbursed by?

- Medicaid Yes No
 - Dental Insurance Yes No
 - Patient Fees Yes No
- If yes, include fee schedule _____
- Free (No Charge) Yes No

Name of Dental Director _____

District of Columbia Dental Society Members Involved in your Activities (attach list if more space needed).

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Amount of Grant Request \$ _____