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 $_____