Oral Health Application

Program Information

Burns Memorial Fund for Children (BMFC) provides financial assistance for children and youth who require urgent or significant dental treatment and whose families are living in low-income households with very limited financial assets.

Families do not require a referral to apply; however, a dental treatment plan and cost estimate from a licensed dentist or dental clinic must be submitted with the application. The Oral Health Program does **not** cover:

- Regular preventive dental care, including check-ups
- Dental exams, consultations, or X-rays
- Braces or any other orthodontic treatment

Burns Memorial Fund may consider up to **$2,000 per family within a three-year period**. Approved funding is paid directly to the dental clinic.

To Apply the Child Must:
☐ Be under 21 years old.
☐ Be a resident of the City of Calgary for at least the past six months.
☐ Live in a household whose income would typically meet low-income thresholds used for municipal programs.
☐ Have a treatment plan provided by a Dentist or Dental Clinic.

An application for the Oral Health Program is attached below. After completing the attached application form, **please submit it along with copies of the following supporting documents:**

Supporting Documents Required
☐ **Proof of all income -** e.g. two months of recent paystubs or bank statements, Employment Insurance (EI), social assistance (Income Support, or AISH) Alberta Works statement, student loan etc.
☐ **Dental Treatment Plan and Cost Estimate -** From a dental care provider.
☐ **Proof of Address -** rental agreement, mortgage statement, or Calgary Housing statement.
☐ **Canada Child Benefit Statement**
☐ **Identification for all children living in the household -** Alberta Health Care Card(s), Alberta Child Health Benefit Card(s), or Alberta Works medical card(s).

It is important to attach everything that is requested, or the application process will be delayed. If something is missing, please explain why.

Please email, fax, or mail the completed application form and supporting documents to the Grant Coordinator via the contact information listed on the final page of the application.

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FAMILY INFORMATION

NAME OF FIRST PARENT/LEGAL GUARDIAN / PRIMARY CONTACT

EMAIL ADDRESS | (H) PHONE NUMBER | (C) PHONE NUMBER

ADDRESS | CITY | POSTAL CODE

JOB TITLE | EMPLOYER

NAME OF SECOND PARENT/LEGAL GUARDIAN

JOB TITLE | EMPLOYER

LENGTH OF TIME APPLICANT HAS LIVED IN CALGARY

HAVE YOU PREVIOUSLY APPLIED TO THE ORAL HEALTH PROGRAM? IF YES, WHAT YEAR?

REFERRED BY?

CHILD RECEIVING DENTAL TREATMENT

NAME	GENDER IDENTITY	AGE	DATE OF BIRTH (DD/MM/YYYY)

ADDITIONAL CHILDREN LIVING AT HOME

NAME	GENDER IDENTITY	AGE	DATE OF BIRTH (DD/MM/YYYY)

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FAMILY FINANCIAL INFORMATION

Please complete all fields of the application. Do not leave any portion of the application blank.

MONTHLY EXPENSES

RENT / MORTGAGE	
TELEPHONE	
UTILITIES (ELECTRICAL / WATER / GAS)	
FOOD	
VEHICLE COSTS (GAS AND MAINTENANCE)	
TRANSIT PASSES	
DAY CARE / BABYSITTING	
MEDICAL	
EDUCATIONAL	
HOUSEHOLD	
OTHER	
TOTAL MONTHLY EXPENSES:	

MONTHLY INCOME

INCOME SOURCE	
EMPLOYMENT INCOME (PARENT/GUARDIAN 1)	
EMPLOYMENT INCOME (PARENT/GUARDIAN 2)	
CANADA CHILD BENEFIT	
SOCIAL ASSISTANCE (AISH, INCOME SUPPORT, ETC.)	
EMPLOYMENT INSURANCE	
PENSION INCOME	
CHILD SUPPORT (CHILD MAINTENANCE PAYMENTS)	
BUSINESS OR SELF - EMPLOYMENT INCOME	
RENTAL INCOME	
OTHER	
TOTAL MONTHLY INCOME:	

ASSETS

		VALUE
VEHICLES		
PROPERTY		
RRSP		
SAVINGS		
OTHER:		
TOTAL ASSETS:		

Please check if you have any of the following:

- ☐ Fair Entry
- ☐ Alberta Child Health Benefit
- ☐ Alberta Child & Family Benefit
- ☐ Canadian Dental Care Plan
- ☐ Other Health Insurance

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CURRENT SITUATION

Please describe your current financial situation, any insurance coverage, the nature of the dental treatment for your child, and any other information BMF should be aware of in the space below. Should you require more space, feel free to attach no longer than one separate page.

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LEGAL DECLARATION OF APPLICANT

I hereby make my application for financial assistance from the Burns Memorial Fund's Oral Health Program for my children; and I declare that:

a) If my circumstances as outlined in this application should change during the granting process, I will notify Burns Memorial Fund;

b) I have truthfully and fully disclosed my financial situation to the best of my knowledge;

c) I consent to the disclosure of relevant and required details related to this application between the dental services provider/referral agency and Burns Memorial Fund;

d) I give my expressed consent to be contacted via email by the Burns Memorial Fund. (If you do not wish to give your expressed consent for email correspondence, please let us know at unsubscribe@burnsfund.com);

e) I make this declaration conscientiously believing it to be true and complete, and of the same force and effect as if made under oath;

SIGNATURE OF APPLICANT **DATE (DD/MM/YYYY)**

BURNS MEMORIAL FUND FOLLOWS LEGISLATED GUIDELINES FOR PRIVACY

Please note: this page must be signed to complete the application. You may print/sign/scan the page or use the "fill and sign" feature in Adobe Acrobat.

SUBMIT APPLICATION TO:

Larasha Farrington (she/her)
Grants Coordinator
Burns Memorial Fund
Kahanoff Centre
1120, 105 12th Ave SE
Calgary, AB, T2G 1A1
T: 587-392-8256 | Fax: 403-233-0513
Larasha.Farrington@burnsfund.com | www.burnsfund.com