Executive Office
85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005
Phone: 847.439.1919
Fax: 847. 439.1569

OSSEOINTEGRATION FOUNDATION
Charitable Grant

The Osseointegration Foundation (OF, or the Foundation) is pleased to provide 10 grants of up to $10,000 to qualifying AO members to subsidize the care of eligible patients. The purpose of the Charitable Grant is to provide financial assistance and improve the lives of individuals diagnosed with a lifetime dental condition or for those who have had severe dental trauma and are unable to receive needed dental therapy due to economic restraints.

ELIGIBILITY
Three categories of funding eligibility are evaluated:

- Care providers
- Patients
- Corporate partners

Within each of these categories are specified criteria that allow for objective consideration of each proposal.

Care Provider Requirements

1. The primary care provider in each grant application must be a member of the Academy of Osseointegration.

2. Student applicants should have a faculty member co-sign indicating that a faculty member will be supervising treatment.

3. The funds provided will be used for the care and treatment of only the individual (i.e., patient) specified in the application. These funds should subsidize all or part of the care needed by the patient, and a commitment to complete therapy and including a 3 year follow-up is implied and required when the provider accepts the grant funding. The patient should not incur any financial obligations. All team members must agree to relieve the patient of any financial responsibilities.

4. Please provide a detailed budget of how the funds will be allocated.

5. Proposals will only be funded if the diagnosis and full treatment plan (including a restorative plan) for a particular patient is submitted for evaluation as part of the proposal. The identity of a patient is irrelevant to the evaluation of any proposal (see attached sample application).

6. Documentation, Initially pre-treatment information, in the form of projection-quality slides and radiographs, is required for each grant-funded case. Patients may be asked to agree to be photographed or filmed in regards to promotional activities by the Osseointegration Foundation. A patient release form will be required for this purpose. At the completion of the patient's care a set of postoperative photographs and slides are required to be submitted.

7. Two-years of follow-up to the Osseointegration Foundation is required. Follow-up should be submitted to the Osseointegration Foundation on an annual basis.

8. Care providers who receive an OF Charitable Grant will not be eligible to reapply for 2 years following receipt of the grant.

Patient Eligibility
For each proposal, please describe how your patient meets the eligibility requirements in each category:

1. **Physical Disability:** There must be presentation of a disability that is amenable to implant therapy and for which implant treatment would significantly improve the patient's functional deficit and lifestyle.

2. **Economic Status:** There must be documented inability to receive needed implant therapy because of economic constraints of the patient. Economic hardship, however, is not the primary or sole criterion for awarding of these grants.

3. **Emotional Well Being:** The benefits of psychological or emotional improvement from implant therapy will be considered in the award selection process.

Note: The Osseointegration Foundation cannot be held responsible nor be subject to prosecution if there are difficulties involved in the course of a patient's treatment.

Corporate Partner Participation
The design of this program requires involvement of OF's commercial partners to provide service and/or hardware for the patients who become grant-funded. **All materials should be donated by the specified company.** Participants must specify the particular products (including manufacturer names) at the time of grant application. Individuals involved in this grant program may not solicit additional funding from these partners or any other organizations for any particular patient's care.

The following guidelines address this aspect of the grant program:

1. Commercial entities should be contacted by the applicant to obtain donations for the required materials. If the applicant does not have a specific company or contact to obtain these donations, the OF will provide a list of potential suppliers.

2. The committee will make every reasonable effort to ensure that requests for commercial support are evenly distributed among potential corporate partners. No single corporate entity is expected to support, by donation, an inequitable portion of services or hardware.

3. Participants in the grant program, including care providers and corporate partners, will receive narrative recognition at all opportunities (i.e. at official Academy meetings), and visual recognition in several forums, including: Academy News; the Academy Bulletin Board in the International Journal of Oral and Maxillofacial Implants; and the Osseointegration Foundation Report.

FOR AN APPLICATION TO BE DEEMED COMPLETE THE FOLLOWING IS REQUIRED:

1. Completed application form
2. Attached information with:
   a) Patient's diagnosis and prognosis
   b) Patient's economic constraints and challenges
   c) Medical risk factors
   d) Treatment plan and budget
   e) List of manufacturers and anticipated equipment that will be supplied and used
   f) A budget list of proposed allocations of requested funding
3. Completed Patient Authorization and Release Form

****Please see grant application example included below****

UPON COMPLETION OF TREATMENT:

1. A summary of the treatment and any changes from the original plan
2. Pre and upon completion, post-operative documentation (including photographs and radiographs).

Grant Selection Process

An independent committee, appointed by the Osseointegration Foundation, will review all grant applications. The number of grants awarded each year is based on the funds available as determined by the Osseointegration Foundation Board of Directors.

Recipients of the award will be notified in writing via the United States Postal Service and email.

Both care providers and corporate partners may use participation in this program for public relations purposes.

Grant Distribution and Criteria

Each grant will be issued upon completion of those portions of the case "when the intended function result is completed," but prior to the requisite three-year follow-up. This Grant does not restrict how or where these funds are to be allocated by the service provider, as long as the entire grant is spent directly on patient care and treatment in the domain of osseointegration. **Under no circumstances will the patient whom is receiving care through this grant program be charged for any services rendered.**

OSSEOINTEGRATION FOUNDATION

Charitable Grant Application

PLEASE TYPE ALL INFORMATION

APPLICANT INFORMATION

Name (AO Member)

_____

FIRST MIDDLE LAST

Address:

_____

STREET

_____

CITY STATE ZIP

_____

COUNTRY

E-mail: _____

Telephone: _____

Fax: _____

Federal ID for Corporation: _____

TEAM MEMBERS

Names, roles and signatures of **ALL** team members consenting to participate in this project is mandatory (attach separate sheet if necessary):

_____I confirm there will be no financial obligation to the indicated patient for any services rendered.

_____ _____

Implant Surgeon Signature

_____I confirm there will be no financial obligation to the indicated patient for any services rendered.

_____ _____

Restorative Dentist Signature

_____I confirm there will be no financial obligation to the indicated patient for any services rendered.

_____ _____

Laboratory Technician Signature

Student applicants only:

_____I confirm supervision of this case by an attending faculty member within my dental school.

_____ _____

School Faculty Member Signature

Please describe, on a separate typed page, the following areas:

1. Completed application form
2. Attached information with:
   a) Patient's diagnosis and prognosis
   b) Patient's economic constraints and challenges
   c) Medical risk factors
   d) Treatment plan and budget
   e) List of manufacturers and anticipated equipment that will be supplied and used
3. Completed Patient Authorization and Release Form

5. List any manufacturers you will be using and if you have already obtained an offer from them to donate supplies or services. Please note that you must supply a post-treatment sheet that specifically names those companies who donated.

Confirmed Implant System (be specific):

_____

Confirmed Grafting Materials (be specific):

_____

Confirmed Barrier Methods (be specific):

_____

Confirmed Materials (be specific):

_____

Submit completed application and accompanying documents by email to:
Osseointegration Foundation
85 W. Algonquin Rd., Suite 550
Arlington Heights, IL 60005
Telephone: 847.439.1919 Fax 847. 439.1569
kimscroggs@osseo.org

Patient Authorization and Release Form

I consent and agree that the photograph(s), or dental image(s) made of me on _____ by _____(dentist's name) may be distributed to and used by the Academy of Osseointegration (AO)/Osseointegration Foundation(OF) or its licensees or assigns for the purposes of public information, public education, training, and for any other purposes AO/OF deems appropriate to inform the dental profession or the general public about the field of implant therapy or tissue replacement therapy.

I have been advised that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photograph(s) may portray features that may make my identity recognizable.

I grant this consent as a voluntary contribution in the interest of public education. I understand that such photograph(s) or medical image(s) shall become the property of the AO/OF and may be shown, published, printed, broadcast or otherwise disseminated in any print, visual or electronic media, specifically including, but not limited to CD Roms, Internet still/video postings, newspapers, television, dental journals and textbooks. I release all discharge from Dr. _____ , the AO/OF, and all parties acting under their license and authority from all rights that I may have in the photograph(s), or dental image(s), including any claim for payment in connection with their distribution or publication.

I understand that, to the extent permitted by law, I have the right to inspect and copy the photograph(s), or medical image(s) that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I do not revoke this authorization, it will expire ten years from the date of its execution.

I understand the photograph(s), or medical image(s) disclosed, or some portion thereof, may be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that because AO/OF is not receiving the photograph(s) or medical image(s) in the capacity of a health care provider or health plan covered by HIPAA, the photograph(s) or medical image(s) may be redisclosed and may not longer be protected by HIPAA.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Patient Name: _____

Address: _____

City, State, Zip: _____

Signature: _____ Email _____

If patient is a minor:

Guardian Name: _____

Address: _____

City, State, Zip: _____

Signature: _____ Email _____

Please return with OF Charitable Grant application to:
Osseointegration Foundation
Attn: Kim Scroggs
85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005