



SPARKLE FUND NOVA SCOTIA

Halifax Region Children's Aid Foundation

Application Information 2017



Program Description:

The Sparkle Fund Nova Scotia was developed to help meet the increasing demand for oral health care for disadvantaged and at risk youth. Applicants to the Sparkle Fund NS must be youth 15-21 years of age who are no longer covered by MSI Quick Card, do not have access to private dental care coverage, and have no family resources or other funding options available. The fund is designed to cover costs of basic dental care as approved by the fund manager. The fund is administered through a partnership between the Sparkle Fund Nova Scotia and the Halifax Region Children's Aid Foundation.

Application Process:

1. The referral agent/ third party/ Doctor/Teacher/ SchoolsPlus Outreach Worker/Social Worker or other professionals to complete all sections of this application form.
2. Submit application by fax or e-mail to fund manager at the address provided below.
3. Fund Manager to review all relevant sections and inform referral agent/applicant of decision to approve or decline the application.
4. Fund Manager will make payment arrangements for approved applications. Receipts and /or invoices will be required for all approved applications.
5. Grants expire six months after the application date and monitoring of the services is the responsibility of the fund applicant.

Fund Manager: Jane Boyd Landry, Executive Director
Halifax Region Children's Aid Foundation
1888 Brunswick St. Suite 301
Halifax, Nova Scotia B3J 3J8
T (902)422-1316 Ext. #4 F (902)422-4012

jane@nscouncilfamily.org www.sparklefund.ca

Basic Dental Care services covered by the Sparkle Fund Nova Scotia to a maximum of \$500 per calendar year. (Jan 1st-Dec 31st). Any treatment costs above \$500 must be brought before the Sparkle Fund NS Committee for consideration.

- One Oral Examination
- Cleaning (one per calendar year)
- Fillings
- Radiographs (x-rays)
- Fluoride Treatment
- Extractions



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Date of Application: _____

About the Applicant:

Name: _____

Birthdate: _____

Gender: _____

Dentist Information:

Dentist: _____

Professional Number: _____

Address: _____

Phone: _____

Description of Request:

Amount Requested: \$ _____

Please provide a clear description of the treatment plan, the expected outcomes and if further treatment will be required. Please attach CDA Form.

Other Sources of Funding Explored? Explain.



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Application Form



Please provide the following information for processing payment of approved applications. Cheques will be issued directly to the requesting dental office. **Invoices for all approved dental work are required in order to receive payment. Only the work approved on the grant application will be paid. Additional work above and beyond the approved treatment will not be covered.**

<p>Amount \$ _____</p> <p><input type="checkbox"/> Mail to address at right</p>	<p>Make cheque payable to:</p> <p>Name:</p> <p>Address:</p> <p>City/Town:</p> <p>Postal Code:</p>
<p>Name of Dentist:</p> <p>Phone Number:</p> <p>E-mail:</p> <p>Office Contact Person:</p>	
<p>Third Party Referral Agent:</p> <p>Address:</p> <p>Phone Number:</p> <p>E-mail:</p>	

For further questions please contact:
Sparkle Fund Nova Scotia
C/O The Halifax Region Children's Aid Foundation
1888 Brunswick St. Suite 301
Halifax NS, B3J 3J8 902-422-1316 Ext. 4
Jane@nscouncilfamily.org www.sparklefund.ca

Thank you for your application to the Sparkle Fund Nova Scotia. We will notify you of your approval status as soon as possible.