

## **Guidelines for Assistance**

### **I. Purpose**

The purpose of the Florida Dental Health Foundation's Disaster Fund is to provide financial assistance to needy eligible beneficiaries, as defined in these guidelines, who are victims of a disaster. This assistance is provided to the eligible applicant in order to maintain or restore the availability of dental care in affected areas. A disaster is defined as a "sudden occurrence which inflicts widespread catastrophic damage to a large geographic area and/or which generally affects a large number of individuals". Examples include, but are not limited to: tornadoes, earthquakes, floods, tidal waves, forest fires, hurricanes, civil unrest, public disturbance, acts of war or terrorism.

### **II. Eligible Beneficiaries**

Any licensed private practicing dentist who is a full-time resident of the state of Florida or any Florida registered dental laboratory may apply to the Florida Dental Health Foundation for financial assistance.

### **III. Types of Assistance**

Assistance provided through the Florida Dental Health Foundation's Disaster Fund includes short-term loans and emergency grants. Loans are provided to supplement insurance coverage to assist in the restoration, repair or reconstruction of an existing practice facility or dental laboratory damaged by a disaster, as defined in Section I of these guidelines. Emergency grants are also available to provide funds to establish a temporary facility to provide dental care or dental laboratory services during the time that repairs are being completed on the applicant's primary practice location or dental laboratory.

### **IV. Circumstances Determining Eligibility for Loans**

Criteria for determining eligibility of disaster loans and grants are listed below. Any application for a disaster loan or emergency grant which does not meet ALL of these criteria will be denied.

- A. As a result of the disaster, the applicant must show that he or she suffered property damages to the dental practice facility or registered dental laboratory owned by the applicant, or the dental equipment and supplies therein. Replacement of lost income from practice interruption is not an eligible reason for assistance.
- B. A "disaster," as defined in Section I of these guidelines, must be declared by a governmental agency, or be determined by the Florida Dental Health Foundation's Disaster Fund Committee to have occurred in the area of the state of Florida in which the applicant seeking assistance operates his or her dental facility or dental laboratory.
- C. The applicant must show that his or her property damages have caused a serious financial hardship and that other sources of adequate funding are not available. Eligibility is determined on a case-by-case basis after evaluating the application form.
- D. The request for a loan or grant must be submitted within 12 months of the time of the disaster.

### **V. Evaluation of Application and Procedures for Processing**

The applicant may obtain an application form from the Florida Dental Health Foundation office. Application forms must be completed in their entirety, signed and dated by applicant requesting assistance.

An application for assistance from the Florida Dental Health Foundation's disaster fund will be reviewed by the Disaster Fund Committee. The applicant requesting assistance will be notified of the decision of the committee as to the approval or denial of the request within 14 days.

## VI. Basis for Assistance

The primary reason for the foundation's Disaster Fund is to assist dentists to continue to provide dental care to communities affected by disasters. Therefore, the applicant shall certify that he or she intends to practice in the disaster affected area for at least the original term of the loan or emergency grant. This certification is part of the application form. If an individual leaves a disaster stricken area to practice elsewhere during the original term of the loan or emergency grant, the Florida Dental Health Foundation shall have the right to immediately call the loan due and seek repayment of the emergency grant.

## VII. Terms of Loans and Grants

The terms of short-term loans and emergency grants from the disaster fund shall be as follows:

- A. Short-term loans will be subject to repayment of the principal plus a five percent (5%) administrative processing fee beginning six months from the date the loan was awarded by the Disaster Fund Committee. The loan and administrative fee can be paid in full or partial installments as determined by the committee, depending on the loan amount. The maximum amount of loan per disaster shall not exceed \$15,000.
- B. Emergency grants shall be awarded on a one-time basis in extreme hardship situations where the public's access to regular and emergency dental care is jeopardized by the damage done to the applicant's dental facility. The grant shall be awarded for the sole purpose of assisting the applicant with costs to maintain a temporary dental facility. These costs shall be limited to lease of office space; purchase or lease of dental equipment and/or purchase of supplies. The maximum amount of the emergency grant shall not exceed \$5,000.

**FLORIDA DENTAL HEALTH FOUNDATION  
DISASTER FUND APPLICATION FORM**

**Personal Information:**

Name of Applicant: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

FL Dental License #: \_\_\_\_\_ Dental Laboratory Registration #: \_\_\_\_\_

**Nature of Disaster:** Provide a description of the nature of the disaster. Attach supporting articles, documents, pictures, etc. Be specific as to time, day, and date in completing this section. (continue on back if necessary)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Amount of Damage:** Structure: \$ \_\_\_\_\_ Equipment: \$ \_\_\_\_\_ Supplies: \$ \_\_\_\_\_

Total Damage: \$ \_\_\_\_\_ Insurance Coverage: \$ \_\_\_\_\_ Net Loss After Insurance: \$ \_\_\_\_\_

**Insurance Company Information:**

Name of Company: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Coverage Amount: \$ \_\_\_\_\_ Deductible Amount: \$ \_\_\_\_\_

**Financial Information:**

Name of Bank: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Checking Account #: \_\_\_\_\_ Savings Account \_\_\_\_\_

Money Market Account #: \_\_\_\_\_ Total Assets: \$ \_\_\_\_\_

Have you applied for a loan from a financial institution to help you in your time of emergency? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Has the loan been denied? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Identification of Other Sources of Aid:**

Small Business Administration: \$ \_\_\_\_\_ Family and relatives: \$ \_\_\_\_\_

Other sources: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

I hereby certify that the information contained in this document is true and complete. I hereby authorize any corporation, firm, agency or institution to furnish to the Florida Dental Health Foundation, Inc. any and all information in its possession relative to my assets, deposits, dealings or business of any kind whatsoever.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**RETURN APPLICATION TO:** Florida Dental Health Foundation, Disaster Relief Assistance  
1111 E. Tennessee Street, Tallahassee, FL 32308 800-877-9922

**FLORIDA DENTAL HEALTH FOUNDATION**

**DISASTER FUND  
CERTIFICATION BY THE APPLICANT**

I certify that I suffered a disaster to my dental practice and/or dental laboratory equipment or supplies as detailed herein on this application.

I intend to continue to practice in this community after this disaster for the term of the disaster loan or emergency grant, if granted. If the loan or grant is granted and I stop practicing in this community, I understand that the outstanding balance of the loan will become due and immediately payable to the Florida Dental Health Foundation, Inc. at the sole discretion of its Disaster Committee. If I was awarded an emergency grant and I fail to complete practice in the community where the disaster took place during the specific time of the grant period as established by myself and the FDHF's Disaster Committee, I agree to repay the entire amount of the grant at the sole discretion of the Disaster Committee.

I certify that the information contained in this application is true and complete. I understand that a fraudulent representation or omission of any information requested in this application is grounds for immediate refusal to grant any loans under this program, and is grounds for the Florida Dental Health Foundation Committee Disaster Committee, at its sole discretion, to declare any outstanding balance due and immediately payable to the Florida Dental Health Foundation.

I understand that the provision of such a loan or grant is neither a right nor entitlement and that the Disaster Committee of the Florida Dental Health Foundation will have the sole discretion in determining whether I qualify for financial assistance under this fund.

I understand I am obligated to provide the Florida Dental Health Foundation, within six months of the granting of a disaster loan or emergency grant, copies of receipts, invoices or bills of sale verifying the use of the loan or grant proceeds for repair or reconstruction of the practice facility/dental laboratory, or for the repair or replacement of damaged equipment and supplies.

I also understand that if I am granted a disaster loan, that I will repay the loan principle and a five percent (5%) administrative fee to the Florida Dental Health Foundation on a payment plan approved by the sole discretion of the Disaster Committee.

I hereby request consideration for:

1. Disaster Assistance Loan in the amount of \$ \_\_\_\_\_ for a term of \_\_\_\_\_ years
2. Emergency grant in the amount of \$ \_\_\_\_\_

I agree to abide by the rules set forth in the Florida Dental Health Foundation Disaster Fund.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Name of witness to Applicant's Disaster: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Notary Public: