Washington Artists Health Insurance Project (WAHIP)
Artist Clinic at Country Doctor / 2009 Clinic Subsidy Eligibility Form (v3.4)

Please provide the information requested below and fax to 206/467-9633:

1. From the list below, what best describes your primary artistic discipline? (Select one)

☐ Visual ☐ Music ☐ Dance
☐ Media ☐ Craft ☐ Theater
☐ Literary ☐ Folk / Traditional artist ☐ Performance
☐ Other (please describe) ____________________

2. In the past year, approximately how much of your time did you spend on your art? (Select one)

☐ Up to 10% ☐ Up to 25% ☐ Up to 50% ☐ Up to 75% ☐ Up to 100%

3. In the past year, approximately what percentage of your income was derived from art? (Select one)

☐ Up to 10% ☐ Up to 25% ☐ Up to 50% ☐ Up to 75% ☐ Up to 100%

4. Please mark which of the following describes your training as an artist. (Select one)

☐ Accredited degree, from: ____________________

☐ Unaccredited workshop/program, from: ____________________

☐ Mentorship / Apprenticeship, with: ____________________

☐ Other, please describe: ____________________

5. Please read the following, regarding potential subsidy payment:

- *Completing this form does not guarantee subsidy payment.*
- *WAHIP reserves the right to determine eligibility.*
- *Funds are available on a first-come, first-served basis.*
- *If you are eligible and funds are available, a $75 voucher will be issued that is applicable toward your bill from Country Doctor Health Centers.*
- *The subsidy is limited to a maximum of two per individual artist during 2009, for a maximum total of $150 during the calendar year.*
- ***All other charges accrued at Country Doctor Community Health Centers or their affiliated services (such as outside laboratory fees) are the sole responsibility of the patient.***

☐ I have read the above and agree with the statement

☐ Yes, I want to be considered for the WAHIP subsidy
☐ No thanks, I don't want to be considered for the WAHIP subsidy

I have Health Insurance ☐ Yes ☐ No

Signature: ____________________

Please Print Name: ____________________
Email: ____________________
Address: ____________________
____

This is my first voucher ☐ This is my second voucher ☐

How did you hear about this clinic? ☐Email notice ☐ Print notice ☐ Other ____________________

To be completed by WAHIP:

Voucher ____________________

Issue Date ____________________

By ____________________

Redeem Date ____________________

Comments: