



## Artist-Client Referral & Application

We Care Arts, Inc.  
3035 Wilmington Pike  
Kettering, OH 45429  
937-252-3937  
[ISP@wecarearts.org](mailto:ISP@wecarearts.org)

**Our Mission:** We empower healing through art and community.

**Our Vision:** A future where people with diverse abilities can achieve their full potential and feel embraced by an inclusive society.

As a 501c3 organization with 40+ years of experience, We Care Arts increases confidence and artistic skill in a variety of individuals with developmental disabilities, substance use disorders, and mental health diagnoses. We bring our mission to life via our ArtWORKS classes which are offered at the Berkeley Center Studio Campus, virtually, in high school Transition to Work classes, as well as through community outreach partnerships, and Supported Employment Services.

We believe every individual is entitled to a fine arts experience. In our studios, learning and growth foster decision making and independence. Applicants may be referred by a professional such as a doctor, therapist, pastor, social worker, occupational/physical therapist, rehab, counselor, or case manager. The referral source shall complete the We Care Arts New Client Application and is required to provide an appropriate release of information form at the time of referral. Please submit the We Care Arts Artist-Client Application and release of information form together. Once the application is received and reviewed, the applicant will be notified to schedule a tour and site interview. Once on-site, we will discuss our program and desired goals of applicant.

### Application Steps:

1. Referring agent completes **Referral Form** (page 1)
2. Applicant, or designated representative with referring agent completes **Mutual Release of Information Authorization** (page 1&2) & Application (pages 3-5)
3. Submit completed referral and application by mail, or email to above address
4. WCA Intake Specialist will reach out to schedule an intake appointment and interview
5. At the interview applicant will take a tour of the facility, discuss goals and expectations, and if accepted, will begin the enrollment process. This can include receiving scheduled class assignment, meeting their instructor, and reviewing where to go on their first day of class.
6. **Bring to Intake Interview:**
  - a. State ID, or proof of residence (utility bill, Medicaid/SS award letter)

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

	<b>REFERRAL FOR SERVICES</b>		
	This form is required to be completed by a qualified referring agent – a professional with a clinical background that is willing to participate in a mutual release of information to allow We Care Arts to better support the applicant.		
Referring Agency		Date	
Address		Phone	
Completed By		Title	
*By signing I attest the applicant has undergone a qualified assessment, and been found to pose minimal risk of harm to self and others		<b>Sign to attest*</b> (required)	

<b>AUTHORIZATION FOR MUTUAL RELEASE OF INFORMATION</b> <i>To be completed by applicant and referring agent</i>	
<b>Note:</b>	All information obtained in association with this Release will be held in strict confidence by the recipient and is not to be further disclosed without specific prior written authorization. Information collected by this Authorization will be used only to provide appropriate support during the term of service. The Ohio Revised Code requires that Authorizations for Release of Information remain in effect for sixty (60) days.  All matters relating to alcohol or drug abuse records are considered privileged and the following Federal Law applies directly to you: P.L. 93-282, 42 CFR, Part 2, prohibits further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.
I agree that this authorization shall remain in effect as indicated:	<input type="checkbox"/> Until termination of services provided by We Care Arts <input type="checkbox"/> Until an expiration date specified in this space: ___/___/___
I understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. Upon revocation of consent, further release of information shall cease immediately.	I hereby grant permission for the mutual release of information relating to my care as indicated below:  <b>To/From:</b> _____  _____ <i>Referring agency name &amp; Address</i>  <b>To/From:</b> We Care Arts 3035 Wilmington Pike, Kettering, OH 45429

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

<b>Mutual Release of Information Authorization Signatures</b>	<b>Applicant's Full Legal Name</b>			
	<b>Applicant's Signature</b>		<b>Date</b>	
	<b>Legally Responsible Other's Name</b>			
	<b>Designee/Legally Responsible Other's Signature</b>		<b>Date</b>	
	<b>Relationship</b>			
	<b>Name of Staff Facilitating Request/Witness</b>			
	<b>Signature of Staff Facilitating Request/Witness</b>		<b>Date</b>	
	<b>Applicant Initial to Authorize Designee* <i>(if applicable)</i></b>		<b>Date</b>	

\*Authorized Designee/Legally Responsible Other is responsible for understanding and ensuring applicant understands and agrees to acknowledgements, waivers, and releases.

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

	<b>Artist-Client Application</b>			
	Must be completed by applicant or designated representative. An incomplete application will not be accepted. If there are questions about the application please call 937-252-3937, or email <a href="mailto:ISP@wecarearts.org">ISP@wecarearts.org</a>			
<b>Legal Name</b>			<b>Birth date</b>	
<b>Preferred Name</b>			<b>Phone</b>	
<b>Address</b>			<b>Apt #</b>	
<b>City</b>		<b>State</b>	<b>Zip</b>	
<b>County</b>			<b>Email</b>	

<b>DEMOGRAPHICS</b>	Demographics information is important for grants and funding requests that make it possible for WCA to continue offering services.			
<b>Select Ethnicity</b>	African American/Black	American Indian/Alaskan	North African/Middle Eastern	Asian/Pacific Islander
Appalachian	Hispanic/Latino	More than one race	White/Caucasian	other
<b>Gender</b>	Female	Male	Trans-female	Trans-male
	Non-binary	My gender is not listed here:		I choose not to respond

<b>FINANCIAL INFORMATION</b>	Financial information is important for grants and funding requests that make it possible for WCA to continue offering services. It is not used to determine eligibility.			
<b>Waiver Status (DODD Medicaid Waiver supported by SSA)</b>	I do not utilize a waiver	I utilize a waiver	I would like information about/help applying for Waiver funded services	
<b>Living Arrangement</b>	Independent	With Family # of people in home _____	Group Home	Other:

<b>MEDICAL/EMERGENCY INFORMATION</b>	Required to better support individuals during a medical emergency or mental health crisis			
<b>Insurance Company</b>			<b>Hospital Preference</b>	
<b>Known Allergies</b>			<b>Emergency/Rescue Medications Prescribed (inhaler, insulin, etc)</b>	
<b>Do you currently, or have you ever had seizures</b>	No	Yes	<b>Date of last seizure:</b>	/ /
<b>Medical Diagnoses</b>			<b>DSM-V Mental Health/Behavioral Health Diagnoses</b>	

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

<b>What do you find most helpful when you are in a stressful situation?</b>				
<b>Are there any agencies that you have received services from within the last year? If so, where?</b>		<b>Are you currently receiving these services?</b>	Yes (explain):	No
<b>In Case of Emergency WCA's procedure is to call 911 and your emergency contact. Is this appropriate for you?</b>	Yes	No	If no, explain:	

*\*NOTICE: WCA reserves the right to contact individuals as needed*

<b>Emergency Contacts</b>	If no emergency contact is available WCA procedure is to call 911			
	<b>Name</b>	<b>Relationship</b>	<b>Phone</b>	<b>Email</b>
<b>Legal Guardian</b>				
<b>If applicable:</b>	I am my own guardian (self-guardian)	Self		
<b>Emergency Contact</b>				
<b>Transportation</b>				
<b>Primary Care Doctor</b>				
<b>Mental Health Professional</b>				
<b>Service &amp; Support Administrator (SSA)</b>		<b>County:</b>		
<b>Anyone Else Important to Know:</b>				

<b>GOALS &amp; PLACEMENT</b>	All participants are encouraged to set 2 goals each year, an art goal, and a life goal. For convenience we have provided some common starting goals, but you are welcome to fill in your own below.	
<b>Art Goal</b>	The applicant will explore various art mediums and techniques to discover their personal preferences, and expand their creative expression	Other:
<b>Life Goal</b>	The applicant will engage in independent and collaborative art activities to build interpersonal skills, such as communication and teamwork.	Other:

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

<b>I learn best by:</b> <i>(circle all that apply)</i>	Someone telling me	Someone showing me	Trying it myself	Written instructions
Have you ever been charged or convicted of a crime?*	No	Yes (explain):		
<i>*NOTICE: WCA reserves the right to conduct a criminal background check on all applicants</i>				
<b>Choice of Location</b>	Berkeley Center (Kettering)	Online/Virtual	Hybrid (combination of in person & virtual)	Town & Country (job training)
<b>DETERMINATION</b>	<b>WE CARE ARTS OFFICE USE ONLY BELOW</b>			
	<b>Accepted</b>		<b>Not Accepted (explain below)</b>	
<b>Notes</b>				
<b>If not accepted: Letter of Ineligibility sent:</b>	/ /			
<b>We Care Arts Representative Name</b>			<b>Date</b>	/ /
<b>We Care Arts Representative Signature</b>				

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

Dec-22



<b>FORM</b>	<b>100</b>
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### ADAMHS Board for Montgomery County

#### Behavioral Health Care Subsidy Application

Section A.

Does Client have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach copy of card	Client's county of residence	Client's Date of birth
Does Client have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach copy of card		/ /
Client's first name and initial if client is a minor		Last name	Client's social security No.

Section B. Financial Party

<b>Financial Party's (who is responsible to pay for the requested services? - Use responsible party's information to determine sliding fee)</b>			
Financial party's and/or client's first name and initial,		Last name	
		Financial party social security No.	
If a joint or family application, spouses first name and initial		Last name	
		Spouse's social security No.	
Home address		Apt. No.	
City, town, or post office, state, and ZIP code.		<b>TAX FILING STATUS</b>	
		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
Calculation of Family Size	Yourself, enter 1	Spouse, enter 1	Enter number of dependents
	+	+	+
			=
Total exemptions (your family)			

For this application, your family size should mirror your exemptions claimed on IRS form 1040 or 1040EZ tax return.

**Enter gross monthly income from your family below. Family size is equal to your total exemptions.**

Section C. Income of Financial Party

If financial party has zero income, check this box <input type="checkbox"/>		<b>Agency Office Use Only</b>  GOSH Reporting: Family size # _____ Adjusted gross monthly income \$ _____  Client's sliding fee co-pay percentage _____ % Subsidy schedule:
1 Wages, salaries, tips, etc. from Form 100-1 (Income Worksheet).	\$ _____	
2 Taxable interest, investment earnings, dividends .....	\$ _____	
3 Alimony Received .....	\$ _____	
4 Business income .....	\$ _____	
5 Pension / retirement / VA pension / Military pay .....	\$ _____	
6 Rental real estate income .....	\$ _____	
7 Farm income .....	\$ _____	
8 Trust fund income .....	\$ _____	
9 Unemployment compensation / TANF/DA .....	\$ _____	
10 Social Security benefits /SSDI/SSI/ VA disability/.....	\$ _____	
11 Child support income .....	\$ _____	
12 Worker's compensation benefits .....	\$ _____	
13 Other (List _____) .....	\$ _____	
14 Exclusions from Form 100-3 (Exclusions Worksheet).....	\$ (- _____ )	
<b>Adjusted Gross Monthly Income Total</b>		
Staple documentation to Form 100 for all items entered above.		

Additional Comments:
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**To the best of my knowledge, the statements on this application are accurate, true and complete.**

Section D. Signatures

<b>Financial Party's signature</b>	<b>Date</b>
<i>During a Crisis Event, the agency's staff member may sign for the client</i>	
<b>I have examined this application and have verified the documents and statements.</b>	
<b>To the best of my knowledge, they are accurate, true and complete.</b>	
<b>Agency staff signature</b>	<b>Date</b>

All sections of this Form 100 must be complete and accurate. To be considered complete and accurate, this Form 100 should be able to be verified by the ADAMHS Board compliance reviewer using the attached supporting documentation.

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

## Explanation of Funding/Cost of Service

We Care Arts is committed to providing service for eligible individuals regardless of ability to pay, and relies on a variety of funding sources to make services accessible for as many people as possible. The average cost for **1 class per week for one person** (3 hours/week) is **\$600 per month or \$7500 annually**. Funding for individuals is dependent on residence and sometimes diagnoses.

Donations to support our program are greatly appreciated and may be tax deductible, but are not expected as a condition for providing service. You can review We Care Arts financials on our website for more information about how funding is allocated:

<https://www.wecarearts.org/who-we-are#Financials>

**Donations can be made on our website:** <https://www.wecarearts.org/take-action#Donate>

Funding Source:	Who is supported:
Medicaid Waiver/Local Funds	Individuals receiving Medicaid waiver services under Ohio Department of Developmental Disabilities/County Board of Developmental Disabilities
Montgomery County Alcohol, Drug Addiction & Mental Health Services	Individuals referred for a variety of mental and behavioral health diagnoses that reside in Montgomery County
Grants, Sponsors, Donations & Fundraising Events	Individuals referred for a variety of mental and behavioral health diagnoses that reside outside of Montgomery County, or lack ability to bill to Medicaid (for ex. requiring an aide that is billing Medicaid in order to fully participate in art class)



# Intake Assessment

Assessment to be completed by WCA Intake Specialist with applicant/designated representative at intake appointment. Questions are intended to determine appropriate supports needed for applicant's success, and goal setting.

**IF NO PLEASE COMMENT BELOW**

<b>COMMUNICATION</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Is able to communicate			
Responds appropriately during conversation			
Displays appropriate social interaction skills (i.e. taking turns, participating in group, free from disturbing utterances, etc)			
Understands the content of ordinary spoken conversations in their primary language			
Communicates adequately with others to make their own needs known			
Is able to read and comprehend printed material			
<b>SAFETY/RISKS</b>			
Can eat independently			
Behaves in such a way as to not cause injury to self or others			
Behaves in such a way as to not cause damage to their own property or the possessions of others			
Can follow basic rules			

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

	Yes	No	Comments
Can take prescription medication without reminders or assistance			
Can follow sterile procedures, administer correct dosage, and complete injection of prescribed medication			
Is free from substance abuse			
Has a history of wandering or elopement			
Is taking any medication we should be aware of			
<b>SUPPORTS</b>			
Can use the toilet independently without reminders or assistance			
Can adequately maintain personal hygiene			
Can get to and from the facility			
Is able to follow directions			
Indicates they could follow a regular schedule			
Needs special accommodation or adaptive equipment			
<b>PLACEMENT &amp; GOAL SETTING</b>			
Has created any kind of art previously, if so what types?			
Shows interest in the program			Rate on a scale of 1-5 with 1 being uninterested, and 5 being enthusiastic

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

	Yes	No	Comments
Is willing to set goals and take steps to achieve them			Rate on a scale of 1-5 with 1 being uninterested, and 5 being enthusiastic:
Is interested in learning general art (please note types)			Rate on a scale of 1-5 with 1 being uninterested, and 5 being enthusiastic:
Is interested in building new peer relationships.			Rate on a scale of 1-5 with 1 being uninterested, and 5 being enthusiastic:
What challenges may prevent applicant from achieving goals?			
What could help the applicant overcome above challenges?			
What day/s of the week are preferred to attend? (Monday-Friday)		What session is preferred?	AM, 9:00-noon PM, 1:00-4:00

Additional Comments:

Applicant Name (last name, first name): \_\_\_\_\_  
DOB: \_\_\_\_\_



## Enrollment Agreement

We Care Arts (“WCA”) is a non-profit organization that serves adults by teaching art, life, job and social skills. Any artwork produced belongs to WCA. If artwork can be sold\* the artist-client will receive up to 30% of the selling price.

Acceptance into the program is determined solely by WCA. If enrolled in the program, WCA reserves the right to remove any client from the program at any time, without cause.

By signing below, I acknowledge I have read the Enrollment Agreement, understand its terms, and wish to participate in the program:

Applicant/Designee Signature		Date:	
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## Bill of Rights Agreement

We Care Arts (“WCA”) is an inclusive community comprised of individuals from all walks of life. Every individual has rights, and if an individual feels that any of the written rights have been violated the individual has the right to have their grievance heard, be responded to quickly, and obtain resolution of the issue. It is the responsibility of WCA to remind the individual of their rights, as well as assist them in understanding the process when an issue becomes a grievance. It is further the responsibility of WCA to help find a suitable advocate for the individual that may require assistance during the grievance process.

By signing below, I acknowledge I have read both the Rights of Persons with a Developmental Disability, and the Rights of a Person with a Mental Health Diagnosis and understand its terms.

Applicant/Designee Signature		Date:	
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Applicant Name (last name, first name): \_\_\_\_\_  
DOB: \_\_\_\_\_



## Waiver and Assumption of Risk

The undersigned, \_\_\_\_\_ (“artist-client”/designee), voluntarily makes and herein after grants this Waiver and Assumption of Risk in favor of We Care Arts (“WCA”): consideration for the opportunity to use facilities, equipment, materials, and/or other assets of WCA and/or to engage in activities, events, festivities, and/or gatherings sponsored by WCA. The artist-client hereby waives releases all claims whether in contract or of personal injury, bodily injury, property damage, damages, losses, and/or death that may arise from my use or receipt.

The artist-client understands and recognizes that there are certain risks, dangers and perils connected with such uses and/or receipt, which the artist-client hereby acknowledges have been fully explained and fully understand, and which the artist-client nevertheless accepts, assumes and undertakes after injury and investigation of extent, duration, and completeness wholly satisfactory and acceptable.

The artist-client further agrees to use their best judgment in undertaking these activities, use, and/or receipt and to faithfully adhere to all safety instructions, and recommendations, whether oral or written.

By signing below the artist-client hereby certifies that they understand this waiver and agree of their own free will, being under no compulsion or duress.

Applicant/Designee Signature		Date:	
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Applicant Name (last name, first name): \_\_\_\_\_  
DOB: \_\_\_\_\_



## Confidentiality Policy for Artist-Clients, Employees, Volunteers, and Board Members

A basic value of We Care Arts is respecting the privacy of the artist-clients, donors, members, staff, and volunteers of We Care Arts, Inc. Personal and financial information is confidential and should not be disclosed or discussed with anyone without permission or authorization from the executive director. Care shall also be taken to ensure that unauthorized individuals do not overhear any discussion of confidential information, and that documents containing confidential information are not left in the open or inadvertently shared.

Artist-clients, employees, volunteers, and board members of We Care Arts, Inc. may be exposed to confidential and/or privileged and proprietary information. It is We Care Arts, Inc.'s policy that such information must be kept confidential during and after the separation or expiration of service.

We Care Arts, Inc. expects you to respect the privacy of other artist-clients. Artist-clients are responsible for maintaining the confidentiality of information relating to We Care Arts' staff, volunteers, or other artist clients.

If there are questions regarding specific confidential information, contact the executive director to discuss the appropriateness of sharing that information including requests from media and government representatives. Unauthorized disclosure of confidential or privileged information is a serious violation of this policy and will subject the person(s) who made the unauthorized disclosure to appropriate discipline up to and including dismissal from programming. This provision does not apply to discussions that are protected by applicable laws.

I agree to treat as confidential all information about current or former We Care Arts community members, and their families that I learn during my time as an artist-client. I understand that it would be a violation of policy to disclose such information to anyone without checking first with the Director of Programming, or the Executive Director

Applicant/Designee Signature		Date:	
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Applicant Name (last name, first name): \_\_\_\_\_  
DOB: \_\_\_\_\_



## Media Consent Form

I understand that as a participant in the We Care Arts (“WCA”) program, my picture and/or life story may be used in promotional material.

Please initial below next to your choice.

I **hereby consent** to the participation in interviews, the use of quotes, and the taking of photographs and/or videos intended for We Care Arts publications, social media, and promotional materials. I grant WCA the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release WCA and its agents and employees from all claims, demands and liabilities whatsoever in connection with the above.

I understand that I may revoke this release at any time by providing WCA with written notice of said revocation. However, a revocation of this release will not be applicable to any materials already produced or in the process of being produced by the organization.

I **do not consent** to have my picture, name or likeness used in WCA publications, social media, or promotional materials without express permission. I acknowledge that opting out may make me ineligible for some activities, as photo documentation may be a requirement to participate.

I agree to treat as confidential all information about current or former We Care Arts community members, and their families that I learn during my time as an artist-client. I understand that it would be a violation of policy to disclose such information to anyone without checking first with the Director of Programming, or the Executive Director

Applicant/Designee Signature		Date:	
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Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_



## Attendance Rules Acknowledgement

We encourage artist-clients to prioritize regular attendance to ensure their success in meeting personal art and life goals. Artist-clients who encounter challenges that affect their attendance should communicate with their instructor, Intake & ISP Specialist, or Education & Curriculum Manager.

### **Attendance Requirements:**

- Maintain a minimum of 70% attendance for each quarter (3 months span).
- Maintain a minimum of 75% attendance for the entire year (12 months span).
- Communicate absences to appropriate WCA staff in advance, or by calling 937-252-3937.

### **Consequences\*:**

- After 3 consecutive weeks of classes missed without communication, artist-client will lose their scheduled seat (be Paused).
- After 2 months of classes missed without communication, artist-client will be disenrolled, and cannot attend classes (be Exited).
- Artist-clients that do not maintain 70% attendance will not be eligible for 6-week classes, Together We Care, or other opportunities with limited space.

*\*Please note that absences due to documented illness, family emergencies or other extenuating circumstances will be reviewed on a case-by-case basis.*

### **Return to Class for Paused & Exited Artist-Clients\*\*:**

- **If paused**, artist-client will need to schedule an appointment to talk with the Intake & ISP Specialist to schedule a return to class and review the attendance policy.
- **If exited**, the individual will need to submit a completed referral and application, **and** schedule an intake appointment with the Intake & ISP Specialist as if they are a new applicant to be able to return to class.

*\*\*Please note: If paused or exited, WCA cannot guarantee availability of your originally scheduled/preferred class, teacher, day and time.*

By signing below I acknowledge that I have read and understand the above attendance requirements.

Applicant/Designee Signature		Date:	
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Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_



**New Artist-Client Onboarding Checklist:**

MARK IF COMPLETED		Explain if unable to complete at this time
	Toured to identify locations of first aid, restrooms, wash stations, emergency exits, and sign-in sheet	
	Review & provide copy of Artist-Client handbook	
	Review Grievance Procedure	
	Review Confidentiality & Privacy Policies	
	Review Rights of Persons Served	
	Review Virtual class option	
	Review Employment Services options, if applicable	
PAPERWORK REQUIRED		
	Complete Referral & Application	
	Complete Intake Assessment	
	Signed Enrollment Agreement	
	Signed Waiver & Assumption of Risk	
	Signed Confidentiality Policy	
	Signed Media Consent	
	Signed Attendance Rules Acknowledgement	
	New goals discussed	
	Completed Form 100	
	Copy of proof of residency	
	Take photo of applicant for digital file	
FINAL STEPS		
	Orient to assigned classroom & sign in/out binder	
	Introduce to assigned instructor <ul style="list-style-type: none"> <li>• Instructor:</li> <li>• Scheduled Day/Time:</li> <li>• Start Date:</li> </ul>	If unable to introduce to instructor, introduce to administrative assistant to ensure a familiar face on first day of class to provide direction.
Applicant/Designee Signature		Date
WCA Representative Name (please print)		
WCA Representative Signature		Date

Applicant Name (last name, first name): \_\_\_\_\_

DOB: \_\_\_\_\_

		<h2 style="margin: 0;">BILLING INTAKE FORM</h2> <p style="margin: 0; font-size: small;"><i>Submit to Bookkeeper after entering artist-client in BrittCo, along with Form 100 &amp; copy of proof of residence</i></p>	
<b>Artist-client Legal Name</b>			
<b>Date of Intake</b>		<b>Time of Intake</b>	
<b>Start Date for class</b>		<b>Scheduled Day &amp; Time</b>	
<b>Teacher</b>		<b>Zone</b>	
<b>COST CENTER</b>			
<b>County of residence:</b>			
<b>Waiver</b>	<b>DODD (state funding)</b>	<b>Enhanced Choice/Local funds (county funding)</b>	
<b>No Waiver</b>	<b>ADAMHS (Mont Co only), poverty guidelines apply</b>	<b>Unfunded (outside of Mont Co)</b>	
	<b>Self Pay</b>		
	<b>Attach Form 100</b>		
	<b>Attach proof of residence</b>		
<b>Notes/Comments:</b>			
<b>Date entered in BrittCo</b>		<b>Initial</b>	
<b>Date entered in BrittCo</b>		<b>QB vendor</b>	
<b>BrittCo Cost Center/Code</b>		<b>Enrolled in GOSH</b>	
<b>Date emailed to Inventory</b>		<b>Initial</b>	
<b>Return Form 100 &amp; proof of residence to Intake Specialist for hard file</b>			