DSHS
WASHINGTON STATE
Department of Social and Health Services

# Adult Assessment Referral

| Referring CSO |
|---|
| Date |

## Section A. Identifying Information

| 1. Client Last Name | First Name | Middle Name | 2. Date of Birth |
|---|---|---|---|
| | | | |

| 3 EJAS ID Number | 4. Gender | 5. Social Security Number | 6. Client Telephone |
|---|---|---|---|
| | | | |

| 7. Message Number | 8. Limited English Proficiency?<br>☐ No ☐ Yes; Primary language: |
|---|---|
| | |

| 8. Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

## Section B. Assessment Appointment Information

| 1. Name of Assessment Center / Entity | 2. Telephone Number |
|---|---|
| | |

| 3. Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| 4. Appointment Date | 5. Appointment Time |
|---|---|
| | |

**Please Note:** Take this form (and any attachments) with you to your appointment. Failure to keep this appointment may result in denial, delay, termination or sanction of your benefits. Failure to accept a program of treatment as prescribed by the assessment center means you refuse treatment, which may result in denial, termination, or sanction. If you have questions about treatment requirements, please ask your CSO worker.

## Section C. To Assessment Center

| 1. Date of Application | 2. Name of Referring Agency, other than CSO (i.e., Hospital, Jail, Detox, etc., if applicable) | 3. Agency Telephone Number |
|---|---|---|
| | | |

4. Client Type (check all that apply)
☐ TANF ☐ Other:

5. Priority Group
☐ Pregnant ☐ CPS Referral ☐ I.V. Drug ☐ HH/Children

**6. The above named client is** (Check appropriate box):
☐ Applicant ☐ Current Recipient ☐ Transfer from another program
☐ A. Title XIX Medicaid eligible. **Provider One Number:** _____
☐ TANF ☐ Other: _____ **or** ☐ Attach printout of medical coverage.

7. ☐ Other incapacity/health problems: _____
☐ A. Other evaluation pending (indicate type and date scheduled): _____
☐ B. Medical / psychological information attached. ☐ Screening information attached.
☐ C. Special needs for this client. Describe: _____

8. Comments / Other:

| 9. WFPS / WFSSS | Telephone Number | 10. Case Worker | Telephone Number |
|---|---|---|---|
| | | | |

Copies to: Client File; Client; Assessment Center

Instructions

The initiating worker:

1. Enters the referring community Services Office (CSO) name and current date.
2. Completes Section A, including the client's full name. The full middle name (not just initial) is requested.
3. Completes Section B when the assessment appointment is established.
4. Completes Section C:
   A. Item 1 designates date the application was initiated.
   B. Completes Items 2 and 3 by entering the name and telephone number of the agency or other entity that prompted the individual to seek chemical dependency services.
   C. Item 4 designates client's program type(s).
   D. Completes Item 5 designating the client's priority category by:
      1) Checking "Pregnant" for anyone currently pregnant or up to two months postpartum;
      2) Checking "CPS Referral" for anyone that is a direct referral for chemical dependency services from Children Protective Services;
      3) Checking "I.V. Drug" for anyone that is an intravenous drug user;
      4) Checking "HH/Children" for individuals with children in the home.

   NOTE: If the client is pregnant, contact the local assessment center immediately for an assessment, as these individuals are fast tracked through the assessment process.

   E. Completes Item 6, as appropriate. If Item A is checked, indicate Title XIX the Provider One number for medical coverage.
5. Completes Items 7 and 8 as needed. Checks Item 7C if the client has a special need.
6. Completes Items 9 and/or 10 with the names and telephone numbers of the referring WFPS / WFSSS.

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