STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Aged, Blind, or Disabled (ABD) Program
Medical Treatment Participation

Client Number:

Date of Birth:

Language:

Hello ,

To remain eligible for the Aged, Blind or Disabled (ABD) program per WAC 388-449-0200, you must participate in:

☐ Mental health treatment if your disability is related to a mental health condition.

☐ Medical treatment if your disability is related to a medical condition.

Please contact us by _____ to discuss the treatment you're receiving.
If you need help accessing treatment or finding a provider, we will do our best to assist you.

To maintain your eligibility for ABD assistance, please provide updated information about your treatment.

You can do one or more of the following to report your participation:

1. Tell us about your treatment. Include provider and dates seen:
   a. Visit your local Community Service Office (CSO) and ask to speak with a Social Service Specialist.
   b. Call the worker listed at the bottom of this letter
   c. Call our Customer Service Center at 1-877-501-2233
2. Provide proof of your appointment notice or have your provider complete the bottom section of this form. Documents may be returned to us by:
   a. Using the drop box at your local CSO or,
   b. Mailing to P.O. Box 11699, Tacoma, WA 98411 or
   c. Faxing to 888-338-7410

If you don't participate in treatment without a good reason, your ABD assistance may end.

_____ _____

Disability Specialist Telephone Number (and area code)

_____

Community Services Office

Aged, Blind, or Disabled (ABD) Program
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This section to be completed by your provider:

Treatment received	
Date treatment received:	
Provider Signature	Print provider name
Clinic, facility, or provider office	
Telephone number (and area code)	