Washington State Department of Social & Health Services
Transforming lives

Client Status Change Report

1. CSO NAME			
2. ASSESSMENT ENTITY (INCLUDING COUNTY)	3. ☐ Initial ☐ Update	4. DATE FORM COMPLETED	

A. Identifying Information

1. CLIENT NAME (LAST, FIRST, MI)		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ACES CLIENT NUMBER	5. CSO APPLICATION DATE	6. TREATMENT PRIORITY	7. ASSESSMENT DATE

B. Assistance Program Type: ☐ ABD / HEN ☐ TANF ☐ SSI ☐ PWA ☐ Other: ______________

1. BEGINNING DATE	2. ENDING DATE	3. MODALITY	
4. AGENCY NAME	MAILING ADDRESS	CITY	ZIP CODE
5. COMMENTS			
1. BEGINNING DATE	2. ENDING DATE	3. MODALITY	
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5. COMMENTS			
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4. AGENCY NAME	MAILING ADDRESS	CITY	ZIP CODE
5. COMMENTS			

C. Assessment Center Closing File

1. CLOSURE DATE	2. CLOSURE REASON (CHECK ONE BOX ONLY)		
	☐ Client died	☐ Incarcerated	☐ Rules violation/non-compliance
	☐ Completed treatment	☐ Moved	☐ Transferred to different facility
	☐ Funds exhausted	☐ No contact/abort	☐ Withdrew against program advice
	☐ Inappropriate admission	☐ Not amenable to treatment	☐ Withdrew with program advice

D. Comments

E. Assessment Counselor

1. NAME	2. TELEPHONE NUMBER ( )