



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Date:

Client Number: _____

Language: _____

Program: _____

You must provide proof you have completed a chemical dependency assessment by _____.
DATE

You have been assessed as dependent on drugs or alcohol. You must provide proof you are participating in chemical dependency treatment by _____.
DATE

If you don't complete an assessment and treatment as required, your Aged, Blind, or Disabled (ABD) cash assistance may end per WAC 388-449-0220.

Chemical Dependency assessment and treatment providers in your area include:

Please call me if you have any questions or if you need help finding a certified chemical dependency assessment or treatment provider.

DISABILITY SPECIALIST

TIME

Telephone: _____

CSO: _____