STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Please return entire form by for

Client Number:

Date of Birth:

Language:

Program:

To remain eligible for cash assistance, you must:

- ☐ Complete a chemical dependency assessment per WAC 388-449-0220.
- ☐ Participate in chemical dependency treatment per WAC 388-449-0220.
- ☐ Participate in mental health treatment associated with your disabling condition per WAC 388-449-0200.
- ☐ Participate in medical treatment associated with your disabling condition per WAC 388-449-0200.

If you don't cooperate without a good reason, your cash assistance may end per WAC 388-449-0200 and 388-449-0220.

Please have the provider of your treatment/services complete this form. It is your responsibility to see that this entire form is returned to me by .

Return to:

Phone:

Fax:

THIS SECTION TO BE COMPLETED BY THE TREATMENT / SERVICE PROVIDER

________________________ provided ________________________ treatment / service.

PROVIDER NAME

Dates or frequency of attendance: ________________________

Progress in treatment: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

This client's participation is satisfactory? ☐ Yes ☐ No

COMMENTS

____

SIGNATURE DATE

____

TITLE PHONE NUMBER

____

AGENCY

____

ADDRESS