STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Date:

Client ID:

Case Worker:

Language:

To remain eligible for the Aged, Blind, or Disabled (ABD) or the Housing and Essential Needs (HEN) Referral program, you must participate in substance use disorder treatment.

Your ABD or HEN Referral eligibility may end if you do not participate in substance use disorder treatment without good cause per WAC 388-449-0220 and 388-447-0120.

Please ask your substance use treatment provider to contact me by phone to verify your participation in treatment. They may also complete this form. If your provider completes this form, please return this form by .

Return to:

Phone:

Fax:

This section is completed by your substance use treatment provider:

_____ was seen for an ☐ assessment or ☐ treatment on the following dates:
CLIENT NAME

_____

Is this client participating in ☐ inpatient treatment or ☐ outpatient treatment?

When is the client scheduled to complete their treatment program? _____

Do you have any recommendations on how we can support the client's participation in treatment or any other comments?

NAME	DATE	TITLE	PHONE NUMBER

AGENCY	ADDRESS