STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Date:

Client Number: _____
Language: _____
Program: _____

☐ You must provide proof you have completed a substance use assessment by _____.
DATE

☐ Your substance use assessment recommends that you complete substance use disorder treatment. You must provide proof you are participating in treatment by _____.
DATE

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

Substance use assessment and treatment providers in your area include:

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

_____ Telephone: _____
SOCIAL SERVICE SPECIALIST TIME

CSO: _____