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: ____________________