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| **State_Seal3**  STATE OF WASHINGTON  DEPARTMENT OF SOCIAL AND HEALTH SERVICES  **Aged, Blind, or Disabled (ABD) Program Medical Treatment Participation**  **Date** | |
|  | Client Number:  Date of Birth:  Language: |
| Hello ,  To remain eligible for the Aged, Blind or Disabled (ABD) program, you must:  Participate in mental health treatment for your disabling condition per WAC 388-449-0200.  Participate in medical treatment for your disabling condition per WAC 388-449-0200.  If you don’t participate in treatment without a good reason, your ABD assistance may end.  **Please contact me by**  **to discuss the treatment you are receiving.** If you need help getting treatment or finding a provider, let me know and I will try to assist you.  When you contact me, we will talk about the following:   1. Your health conditions that are making it difficult for you to work. 2. The providers you are seeing for treatment. 3. How often you have appointments with your providers. 4. What I can do to help support your treatment.   Thank you. I look forward to connecting with you.  DISABILITY SPECIALIST PHONE NUMBER  COMMUNITY SERVICES OFFICE | |