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| STATE OF WASHINGTON  **DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  Date: | |
|  | Client Number:  Case Worker:  Language: |
| Hello,  We weren’t able to confirm that you:  Completed a substance use assessment as required in the letter dated  .  Participated in substance use disorder treatment as required in the letter dated  .  Your Housing and Essential Needs (HEN) Referral eligibility will end unless you provide proof you have met this requirement or have a good reason for not participating per WAC 388-447-0120.    Please:  Meet with me on  at  DATE TIME  Call me at  by  to discuss why you were not able to participate.  PHONE NUMBER DATE  You may also send me a written explanation of why you were not able to participate by  .  DATE  Include any proof you have, such as a statement from your medical or treatment provider, with your letter.  Comments: | |
| I look forward to speaking with you.  Telephone:   DISABILITY SPECIALIST  CSO: | |