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|  | ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWD)  **ABAWD Requirement:**  **Medical Report**  Please use blue or black ink. | | DSHS MAILING ADDRESS  **DSHS, PO BOX 11699**  **TACOMA WA 98411-9905** | | |
| DSHS PHONE NUMBER  **(     )** | | DSHS FAX NUMBER  **888-338-7410** |
| CASE / CLIENT ID NUMBER | | |
| **Section 1. To be filled out by the client** | | | | | |
| CLIENT NAME (PLEASE PRINT) | | | SOCIAL SECURITY NUMBER (OPTIONAL) | | |
| **Patient / Client participant’s authorization:**  I authorize the release of medical information and/or rehabilitation participation requested to the Department of Social and Health Services.    PATIENT / CLIENT PARTICIPANT’S SIGNATURE DATE | | | | | |
| **Section 2. To be filled out by a medical professional \*\*** | | | | | |
| Please answer one or more of the following questions in the box below. Please sign and date this form including your profession or position in your agency. \*\*  1. Is this individual pregnant?  Yes  No  Unknown  If yes, due date:  2. Is this individual a participant in a vocational rehabilitation program, a mental health counseling program, or a drug or alcohol treatment or counseling program?  Yes  No  If yes, anticipated program end date:  3. Does this individual have a mental and/or physical illness or disability, temporary or permanent, which would prevent them from working 20 hours a week?  Yes  No  If yes, please indicate the how long their condition would prevent them from working 20 hours a week:  Less than 30 days  1 – 3 months  3 – 6 months  6 – 9 months  9 – 12 months  More than 12 months or indefinite | | | | | |
| **I certify the information provided above is true and accurate.** | | | | | |
| SIGNATURE DATE SIGNED | | | | PHONE NUMBER (WITH AREA CODE)  **(     )** | |
| PRINT NAME HERE | | TITLE / PROFESSION\*\* | | | |
| ADDRESS CITY STATE ZIP CODE | | | | | |