



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Please return entire form by _____ for _____

Client Number: _____

Date of Birth: _____

Language: _____

Program: _____

To remain eligible for cash assistance, you must:

- Complete a chemical dependency assessment per WAC 388-449-0220.
- Participate in chemical dependency treatment per WAC 388-449-0220.
- Participate in mental health treatment associated with your disabling condition per WAC 388-449-0200.
- Participate in medical treatment associated with your disabling condition per WAC 388-449-0200.

If you don't cooperate without a good reason, your cash assistance may end per WAC 388-449-0200 and 388-449-0220.

Please have the provider of your treatment/services complete this form. It is your responsibility to see that this entire form is returned to me by _____.

Return to: _____

Phone: _____

Fax: _____

THIS SECTION TO BE COMPLETED BY THE TREATMENT / SERVICE PROVIDER

_____ provided _____ treatment / service.

PROVIDER NAME

Dates or frequency of attendance: _____

Progress in treatment: Excellent Good Fair Poor

This client's participation is satisfactory? Yes No

COMMENTS

SIGNATURE DATE

TITLE PHONE NUMBER

AGENCY

ADDRESS