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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 |