Washington State Department of Social & Health Services
Transforming lives

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

** This form may be signed by any of the following: physician, physician's assistant, designated representative of the physician's office, nurse practitioner, osteopath, licensed or certified psychologist, drug and alcohol abuse counselor, certified mental health counselor, licensed independent clinical social worker, licensed certified social worker, or certified midwife. For purposes of verifying an individual's participation in a rehab or counseling program (Section 2), the director of the program or the individual's counselor may also sign this statement.