STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

[Community Services Office (CSO) Address & Phone Number]

[Date]

[Client Name]
[Client Address]
[Client Address]

[Client ID Number]
Program~~Language~~:
Language~~Program~~:
~~DOB:~~

You need to give us current medical information. If you want to keep getting General Assistance, we need to receive this information before [date]. If we do not receive this information, your cash and medical benefits may stop. If you need help, contact me right away.

We need the following information:

Take the enclosed form(s) to the medical provider or therapist you see most often for treatment.

~~Your financial assistance is based on a decision that you are incapacitated from gainful employment. That decision established your incapacity to exist through [Date].~~

~~If you believe you will be incapacitated after the above date and are eligible for continued financial assistance, you must give me a current medical report from your doctor or qualified health professional on or before **[Date].** Your failure to do so may cause your financial assistance to be terminated because we will not know if you are still incapacitated.~~

When we get this information, we will decide ~~After we have received the medical report, a decision will be made whetherif~~ you will still qualify for General Assistance~~r incapacity continues to exist~~. ~~Your financial worker~~We will mail you a notice ~~of that decision~~ at least 10~~ten~~ days before we make changes to your benefits ~~your current eligibility period is due to end~~.

~~We must have the following medical or other information to review the case:~~

Call me if you need help ~~in gathering this information~~ or have any questions about your case.

_____ Telephone:

DRAFT

[Social Worker Name] [CSO Name]

~~Incapacity Specialist~~Social Worker

DSHS 14-217(x) (09~~02~~/2006~~1996~~) TRANSLATED

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