CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT B

Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Observation

CLIENT NAME		CLIENT SAMPLE ID NUMBER
DATE OF CLIENT OBSERVATIONS	☐ Observations in client home	OTHER LOCATION

Brief Review of PCSP / ISP, IISP, PBSP, IFP (list any area of concern)

The information listed in the left box of each category is a guideline, document observations in the right box.
If no observation occurred, mark the "Not Observed" box for that section.

A. Staff / Client Interactions	**Time of Observation:**	☐ **Not Observed**
What staff instruction and supports were observed?	Staff name:	

B. Meals	**Time of Observation:**	☐ **Not Observed**
What meal(s) were observed?		
Any dietary restrictions?		
Did the meal appear balanced and nutritious?		
Were the restrictions accommodated?	☐ Yes ☐ No	

C. Medication Assistance	**Time of Observation:**	☐ **Not Observed**
What kind of assistance did the client require for medications?		
Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble.	☐ Staff ☐ Client	
How did the client take their pills?		
Was the medication mixed in food? (388-101D-0310)	☐ Yes ☐ No	
Was the medication crushed?	☐ Yes ☐ No	

Notes: