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

ATTACHMENT F

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

CCRSS Certification Evaluation Family / Representative / Collateral Contact Interview

CLIENT NAME	CLIENT SAMPLE ID NUMBER
DATE OF INTERVIEW	TIME OF INTERVIEW

☐ If interview is not with a court-appointed guardian, check here if the client did not give permission for a collateral interview. If the box is checked, skip rest of form, and move on.

CONTACT NAME AND NUMBER	RELATIONSHIP TO CLIENT
CONTACT ATTEMPTS	

What do you like about the services the provider provides to the client?

Does the provider and staff provide the support to the client in a manner that encourages the client to do things for themselves to learn and grow? Please describe.

Are there any areas the provider and their staff could improve upon?

Do you have any concerns about the care the client receives?

Are there any services or assistance that you would like to see that is not currently offered?