|  CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
|  |  ATTACHMENT B AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Supports Observation** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF CLIENT OBSERVATIONS (OBSERVATIONS IN CLIENT HOME UNLESS OTHERWISE NOTED) |
| **If no observation occurred, mark the “Not Observed” box for that section.** |
| **A. Staff / Client Interactions Time of Observation:       [ ]  Not Observed**  |
| Staff name(s):  |
| YES | NO | N/A |  | YES | NO | N/A |  |
| [ ]  | [ ]  | [ ]  | Were staff to client interaction(s) responsive and meeting client needs? | [ ]  | [ ]  | [ ]  | Was staff / client communication appropriate? |
| [ ]  | [ ]  | [ ]  | Did staff refrain from speaking over clients or in another language? | [ ]  | [ ]  | [ ]  | Was there recognition of the client’s cultural diversity and preferences? |
| [ ]  | [ ]  | [ ]  | Did staff respect the client’s dignity, privacy, and rights? |  |
| **B. Meals Time of Observation:       [ ]  Not Observed**  |
| [ ]  Same staff as observed during interventions. | Staff name(s), if different:  |
| What meal(s) were observed? |
|  |
| Does the client participate in meal choice? |
|  |
| Are there doctor’s orders for dietary restrictions? [ ]  Yes [ ]  No If yes, explain restrictions:  |
|  |
| If yes, were the restrictions accommodated? [ ]  Yes [ ]  No |
| **C. Medication Assistance Time of Observation:       [ ]  Not Observed**  |
| [ ]  Same staff as observed during interventions. | Staff name(s), if different:  |
| Who prepared the medications? [ ]  Staff [ ]  ClientDid the client receive assistance as identified in their PCSP? [ ]  Yes [ ]  NoWas the medication crushed or mixed in food (WAC 388-101D-0310)? [ ]  Yes [ ]  No |
| **D. Notes**  |
|  |
| Text  Description automatically generated |  ATTACHMENT C AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Interview** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF CLIENT INTERVIEW | TIME OF CLIENT INTERVIEW |
| Document client answers to the questions or declination to answer the questions on the right side of the box. Ask at least one question or a related question for Section A - J. [ ]  **Check here if the client is not capable of being interviewed.** [ ]  **Check here if the client declined the entire interview.** |
| **If a box above is checked, skip rest of form, and move to next form.** |
| **The following are REQUIRED questions and MUST be asked during the interview. Check “Y,” if the answer is yes; check “N,” if answer is no and document the interviewee’s response; or check “D,” if the interviewee declined to answer the question; or check “N/A” if the question was not asked because it does not apply to that client (i.e., client does not have a roommate). The questions in this section were developed with CMS as part of a waiver and CANNOT be modified.** |
|  Y N D N/A[ ]  [ ]  [ ]  [ ]  Can you make choices about the care and services you receive here at the home?[ ]  [ ]  [ ]  [ ]  If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to?[ ]  [ ]  [ ]  [ ]  Do you have an opportunity to participate in community activities? |  Y N D N/A[ ]  [ ]  [ ]  [ ]  Can you choose who visits you and when?[ ]  [ ]  [ ]  [ ]  Do they pay attention to what you have to say?[ ]  [ ]  [ ]  [ ]  Can you choose to lock your door?[ ]  [ ]  [ ]  [ ]  Do you have access to food anytime?[ ]  [ ]  [ ]  [ ]  Do you receive services in the community?Notes:  |
| **A. Overall Satisfaction and Responses to Concerns** **[ ]  Declined to Answer** |
| What do you like about living here?  |
| **B. Care and Service Needs [ ]  Declined to Answer** |
| Do you get the help that you need? |
| **C. Support of Personal Relationships [ ]  Declined to Answer** |
| Do you have friends or relatives in the community that you visit with?  |
| **D. Restrictions [ ]  Declined to Answer** |
| Do you get to do things you want to do?  |
| **E. Respect of Individuality, Independence, Personal Choice, Dignity (meals, activities, money) [ ]  Declined to Answer** |
| Can you make your own choices?  |
| **F. Environment [ ]  Declined to Answer** |
| Tell me about your room is decorated and did you help?  |
| **G. Health and Safety [ ]  Declined to Answer** |
| Do you feel safe here?  |
| **H. Food / Shopping / Preferences [ ]  Declined to Answer** |
| Do you have your own food? Are you happy with it? |
| **I. Social Activities / Work [ ]  Declined to Answer** |
| What kinds of things did you do for fun?  |
| **J. Finances [ ]  Declined to Answer** |
| Do you get to spend some money the way you want? |
| **Notes** |
|  |
| Text  Description automatically generated |  ATTACHMENT D AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Finances Record Review** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| **Finances** |
| Does the provider manage client funds? [ ]  Yes [ ]  No  |
| IFP signed by client and legal representative? [ ]  Yes [ ]  No  |
| Are there staff that may assist? [ ]  Yes [ ]  No  |
| Is each type of client funds tracked separately? [ ]  Yes [ ]  No  |
| Are funds deposited timely? [ ]  Yes [ ]  No  |
| Prevented client account from being overdrawn? [ ]  Yes [ ]  No  |
| Any fees or late charges? [ ]  Yes [ ]  No  |
| Any provider loans? [ ]  Yes [ ]  No  |
| Any provider loans? [ ]  Yes [ ]  No  |
| Mismanaged / lost / stolen funds? [ ]  Yes [ ]  No  |
| Property record? [ ]  Yes [ ]  No  |
| **Reconcile the client’s home cash account ledger to the actual amount of cash on hand:** |
|  | Checking | Cash | EBT | Gift Card |
|  | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Ledger | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Reconciled / verified monthly (two different staff) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Receipts over $25 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Running balance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **WACs:** 388-101-3020 (Compliance)388-101D-0235 (Shared expenses and client related funds)388-101D-0240(1,6,9) (Individual financial plan)388-101D-0245(8) (Managing client funds) | 388-101D-0255 (Reconciling and verifying client accounts)388-101D-0270 (Client financial records)388-101D-0285 (Client reimbursement)388-101D-0390 (Client’s property record) |
| **Notes** |
|  |
| Text  Description automatically generated |  ATTACHMENT E AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Record Review** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| **Client Characteristics** |
| Level 5+[ ]  | G[ ]  | VP[ ]  | AE[ ]  | NEW[ ]  | ND[ ]  | NV[ ]  | MED[ ]  | PBS[ ]  | RES[ ]  | CP[ ]  | WORK[ ]  | $[ ]  | GH[ ]  | CDBS / CDSS[ ]  |
| Diagnoses:  |
| **PCSP** |
| Effective date: Notes: |
| **IISP** |
| IISP; date:  |
| Yes No [ ]  [ ]  6-month review [ ]  [ ]  Goals defined and implemented | Yes No [ ]  [ ]  IISP with methods [ ]  [ ]  IISP approval | Yes No [ ]  [ ]  Implementation of goals [ ]  [ ]  Risk and interventions identified |
| Notes: |
| **Medical Information** | **Medical Devices** |
| Physical date: Dental date: Follow-up on medical: Other medical (podiatry, eye, etc.): Protocols:  |  Yes No N/ACurrent doctors’ orders? [ ]  [ ]  [ ] Consent? [ ]  [ ]  [ ] Instructions / plan? [ ]  [ ]  [ ]  |
|  | Notes: |
| Nurse Delegation: [ ]  Yes; (if yes, complete below) [ ]  No |
| Yes No [ ]  [ ]  Consent (date: ) [ ]  [ ]  Instructions available to staff [ ]  [ ]  90 Day Review | Reason for Nurse Delegation (check all that apply) |
|  | [ ]  Topical [ ]  Oral [ ]  Nasal [ ]  Rectal [ ]  Drops: eye [ ]  Drops: ear [ ]  Insulin [ ]  Blood Glucose[ ]  G-Tube (date) [ ]  Other:  |
| Notes: |
| **PBSP and Functional Assessment** |
| PBSP Date: [ ]  N/ARestrictive procedures: [ ]  Yes [ ]  No If yes, complete below:Date: Yes No N/AClient / guardian consent [ ]  [ ]  [ ] Housemate consent [ ]  [ ]  [ ]   | Functional Assessment date:[ ]  N/A Yes No N/ATarget behavior [ ]  [ ]  [ ] Behavior function [ ]  [ ]  [ ] Finalized within 45 days [ ]  [ ]  [ ]  |
| Notes: |
| Community Protection (CP): [ ]  Yes [ ]  No If yes, complete below: |
|  Yes No N/ATreatment plan (date: ) [ ]  [ ]  [ ] CP chaperone agreement [ ]  [ ]  [ ] CP site approval [ ]  [ ]  [ ]  |  Yes No N/AMixed CP housing (date: ) [ ]  [ ]  [ ] Psychosexual / CP risk assessment [ ]  [ ]  [ ] Sex Offender Registration Required [ ]  [ ]  [ ]  |
| **Medications** |
| MAR ReviewDates of MAR:  Yes No N/AMedications on hand match MAR [ ]  [ ]  [ ] Staff initials on MAR indicate medications given as prescribed for the month [ ]  [ ]  [ ] Medication list and purpose [ ]  [ ]  [ ] Expired medications [ ]  [ ]  [ ] Medications labeled / manufacturer’s instructions [ ]  [ ]  [ ]  |
| Notes: |
| Psych Meds: [ ]  Yes [ ]  No; if yes, complete below: Yes NoInstructions available to staff? [ ]  [ ] Monitoring side effects? [ ]  [ ] Psych med list and purpose [ ]  [ ]  | Date met with prescriber: Provider present? [ ]  Yes [ ]  NoIf no, who accompanied client?  |
| **Incident Reports** |
|  |
| **Release of Information** |
|  |
| **Notes** |
|  |
| **Related WACs** |
| **388-101D-0025** Service provider responsibilities**388-101D-0060** Policies and procedures**388-101D-0130** Treatment of clients**388-101D-0150** Client health services support**388-101D-0150 (5)** Health services monitoring **388-101D-0150(7)** Annual physical / dental**388-101D-0155** Medical devices**388-101D-0180** CP and other clients**388-101D-0205** IISP**388-101D-0210 (2)(b)** IISP Development - instruction and support**388-101D-0215** IISP Documentation**388-101D-0215(5)** IISP Documentation (agreement)**388-101D-0230** Ongoing IISP updates**388-101D-0355** Psychotropic Medications | **388-101D-0370** Confidentiality of client records**388-101D-0385** Contents of client records**388-101D-0385(2)(d)** Health provider contact information**388-101D-0405** When is F.A. required?**388-101D-0410** When is PBSP required?**388-101D-0425(2)(c**) Restrictive procedures-PBSP strategies**388-101D-0425(3**) Restrictive procedures - termination of**388-101D-0470(2)** CP policies and procedures - chaperone**388-101D-0470(3)** CP policies and procedures - compliance with laws**388-101D-0485** CP treatment plan**388-101D-0490(1)** CP client records – psychosexual / risk assessments**388-101D-0500** CP client home location**388-101-4150** Mandatory Reporting-CRU**388-101-4160** Mandatory Reporting-Law Enforcement |
|  |
| Text  Description automatically generated |  ATTACHMENT F AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Representative Interview** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| If the client represents themselves:[ ]  Check here if they did not give permission for an interview with family, representative, case manager or other identified contact and skip the rest of the form.If the client has a legal guardian attempt two contacts to their guardian and record below.[ ]  Check here if guardianship documents are expired, skip the rest of the form. |
| CONTACT NAME | CONTACT NUMBER | RELATIONSHIP TO CLIENT |
| CONTACT ATTEMPT 1Date:Time:Result (i.e., left message):  | CONTACT ATTEMPT 2Date:Time:Result (i.e., left message):  |
| DATE OF INTERVIEW | TIME OF INTERVIEW |
| 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? |
| **Notes** |
|  |
| Text  Description automatically generated |  ATTACHMENT G AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Staff Interview** |
| CLIENT NAME  | CLIENT SAMPLE ID NUMBER | DATE OF INTERVIEW |
| STAFF NAME  | STAFF SAMPLE ID NUMBER | TIME OF INTERVIEW |
| **A. Client Needs**  |
| Tell me about the instruction and supports that you provide to client. |
| **B. Client Health Care and Medication** [**WAC 388-101D-0185**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0185) **(services),** [**WAC 388-101D-0325**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0325) **(medications)** |
| Tell me about client health care needs / medical concerns. |
| What time do clients take their medications?  |
| Where are medications and MARs kept? |
| Where can you find information on the purpose and side effects? |
| Are there nurse delegations for any task? |
| What do you do if a client refuses or declines medication? |
| **C. Finance / Food / Meals** [**WAC 388-101D-0235**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0235) |
| What assistance does the client need to pay bills and buy food? |
| If clients eat family style meals, how do you ensure one client is not contributing more food? |
| Is the client on a special diet? How do you assist? |
| **D. Mandatory Reporting** [**WAC 388-101-4150**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101-4150)**,** [**WAC 388-101-4160**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101-4160) |
| Are you trained on Mandatory Reporting? |
| What would you do if you suspected a client was being abused, neglected, or financially exploited? |
| **E. Positive Behavior Support Plan** [**WAC 388-101D-0400**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0400)**,** [**WAC 388-101D-0405**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0405)**,** [**WAC 388-101D-0410**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0410) |
| How do you access the PBSP? |
| What behaviors are noted? |
| **F. Notes** |
|  |

| CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
| Text  Description automatically generated |  ATTACHMENT P AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Group Training Home (GTH) Client Environment and Safety Worksheet** |
| Observations of the environment occur throughout the certification evaluation process. |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF OBSERVATIONS | TIME OF OBSERVATIONS |
| 1. **Quality of Life / Client Rights WAC 388-101D-0695**
 |
| Yes | No | N/A |  |
| [ ]  | [ ]  | [ ]  | Was the client’s bedroom furnished and decorated within the term of their written agreement with the GTH? |
| [ ]  | [ ]  | [ ]  | Can client retain and use personal possessions, including furniture and clothing, as space permits? |
| [ ]  | [ ]  | [ ]  | Does the client have control of their own schedule as indicated in their PCSP? |
| [ ]  | [ ]  | [ ]  | Does the client have a written agreement with the GTH regarding client’s notice of rights for termination? |
| [ ]  | [ ]  | [ ]  | Was adaptive / life sustaining equipment available, clean, and in good repair? |
| 1. **Bedroom WAC 388-101D-0565, 0580, 0695**
 |
| Yes | No | N/A |  |
| [ ]  | [ ]  | [ ]  | Is the bedroom private unless client requests to share? |
| [ ]  | [ ]  | [ ]  | Window / door provides natural light. Covered with a screen, and allows for emergency exit? |
| [ ]  | [ ]  | [ ]  | Does the room have a closet or wardrobe? |
| [ ]  | [ ]  | [ ]  | Does the room have a locking bedroom door (unless unsafe for client per PCSP)? |
| [ ]  | [ ]  | [ ]  | Clean, comfortable bed with waterproof mattress if needed or requested by client? |
| [ ]  | [ ]  | [ ]  | Adequate space for mobility aids (i.e., wheelchair, walker, lifting devices)? |
| [ ]  | [ ]  | [ ]  | Direct, unrestricted access to common areas? |
| [ ]  | [ ]  | [ ]  | Home has been adapted to meet the client’s needs? |
| 1. **Notes**
 |
| NOTES |