| CCRSS PROVIDER NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | CERTIFICATION NUMBER | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | | | | | | | | | | | | | | | | | | | | | | | | CERTIFICATION EVALUATION DATE(S) | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | 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  Client  Did the client receive assistance as identified in their PCSP?  Yes  No  Was the medication crushed or mixed in food (WAC 388-101D-0310)?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **D. Notes** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Text  Description automatically generated | | | | ATTACHMENT D  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  CERTIFIED 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Text  Description automatically generated | | | | ATTACHMENT E  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  CERTIFIED 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/A  Current 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/A  Restrictive procedures:  Yes  No  If yes, complete below:  Date:  Yes No N/A  Client / guardian consent  Housemate consent | | | | | | | | | | | | | | | | | | | | | | Functional Assessment date: N/A  Yes No N/A  Target behavior  Behavior function  Finalized within 45 days | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Protection (CP):  Yes  No If yes, complete below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes No N/A  Treatment plan (date: )  CP chaperone agreement  CP site approval | | | | | | | | | | | | | | | | | | | | | | | | Yes No N/A  Mixed CP housing (date: )  Psychosexual / CP risk assessment  Sex Offender Registration Required | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAR Review  Dates of MAR:  Yes No N/A  Medications 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 No  Instructions available to staff?  Monitoring side effects?  Psych med list and purpose | | | | | | | | | | | | | | | | | | | Date met with prescriber:  Provider present?  Yes  No  If no, who accompanied client? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Incident Reports** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Release of Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Notes** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Text  Description automatically generated | | | | | ATTACHMENT F  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  CERTIFIED 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 1  Date:Time:  Result (i.e., left message): | | | | | | | | | | | | | | | | | | | | | | | CONTACT ATTEMPT 2  Date: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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | |