| 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 SERVICESCERTIFIED 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? |