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 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

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

ATTACHMENT C

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 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?
☐	☐	☐	☐	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?

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

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

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

ATTACHMENT D

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 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

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

ATTACHMENT E

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 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		Yes	No		Yes	No	
☐	☐	6-month review	☐	☐	IISP with methods	☐	☐	Implementation of goals
☐	☐	Goals defined and implemented	☐	☐	IISP approval	☐	☐	Risk and interventions identified

Notes:

Medical Information

Physical date:

Dental date:

Follow-up on medical:

Other medical (podiatry, eye, etc.):

Protocols:

Medical Devices

	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:

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

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	☐	☐	☐
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

Release of Information

Notes

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

Related WACs	
388-101D-0025 Service provider responsibilities	**388-101D-0370** Confidentiality of client records
388-101D-0060 Policies and procedures	**388-101D-0385** Contents of client records
388-101D-0130 Treatment of clients	**388-101D-0385(2)(d)** Health provider contact information
388-101D-0150 Client health services support	**388-101D-0405** When is F.A. required?
388-101D-0150 (5) Health services monitoring	**388-101D-0410** When is PBSP required?
388-101D-0150(7) Annual physical / dental	**388-101D-0425(2)(c**) Restrictive procedures-PBSP strategies
388-101D-0155 Medical devices	**388-101D-0425(3**) Restrictive procedures - termination of
388-101D-0180 CP and other clients	**388-101D-0470(2)** CP policies and procedures - chaperone
388-101D-0205 IISP	**388-101D-0470(3)** CP policies and procedures - compliance with laws
388-101D-0210 (2)(b) IISP Development - instruction and support	**388-101D-0485** CP treatment plan
	388-101D-0490(1) CP client records – psychosexual / risk assessments
388-101D-0215 IISP Documentation	**388-101D-0500** CP client home location
388-101D-0215(5) IISP Documentation (agreement)	**388-101-4150** Mandatory Reporting-CRU
388-101D-0230 Ongoing IISP updates	**388-101-4160** Mandatory Reporting-Law Enforcement
388-101D-0355 Psychotropic Medications	

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

ATTACHMENT F

Washington State Department of Social & Health Services
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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	CONTACT ATTEMPT 2
Date: Time:	Date: Time:
Result (i.e., left message):	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

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

ATTACHMENT G

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 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 **(services),** WAC 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

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, WAC 388-101-4160

Are you trained on Mandatory Reporting?

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
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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, WAC 388-101D-0405, WAC 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)

ATTACHMENT P

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 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

A. 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?

B. 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?

C. Notes

NOTES