| 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? | | | | |