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

ATTACHMENT F

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 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