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

ATTACHMENT A

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 Face Sheet

CCRSS Provider Information		
DOING BUSINESS AS (DBA)	TELEPHONE (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)
MAILING ADDRESS		EMAIL ADDRESS
PHYSICAL ADDRESS		
ADMINISTRATOR'S NAME	EVALUATION TEAM (INDICATE TEAM LEADER)	
NUMBER OF CLIENTS SERVICE BY PROVIDER	SAMPLED CLIENTS ID NUMBERS	
NUMBER OT TOTAL PERSONNEL EMPLOYED BY PROVIDER	SAMPLED PERSONNEL ID LETTERS	

Enter sample Client ID numbers for the following in the column below	**Enter total number of clients in the column below**
Clients receiving **Group Home Services**:	
Clients receiving **Nurse Delegation**:	
Clients receiving **Community Protection Services**:	
Clients with **Positive Behavior Support Plans**:	
Clients **Prescribed Psychoactive Medications**:	
Clients with **Vocational / Employment Programs**:	
Clients with **Restrictive Procedure***:	
Clients **Performing Work for the Provider Requiring Remuneration**:	
Clients Assessed at **Level 5+**:	
Clients whose **Funds are Managed by Agency**:	
Clients receiving **Crisis Diversion Bed Services****:	
Clients receiving **Crisis Diversion Support Services*****:	
Total number of **Vehicle(s) Operated by Provider**:	Insured? ☐ Yes ☐ No If yes, insurance company name (notify FM if no insurance):
Other information gathered:	
Alternate office sites:	

* **Restrictive procedure**: Any procedure that restricts a client's freedom of movement, access to client property, requires a client to do something, which s/he does not want to do, or removes something the client owns or has earned. Examples: locked sharps, window / door alarms, locked food, etc.

** **Crisis diversion bed services:** Crisis diversion that is provided in a residence maintained by the service provider.

*** **Crisis diversion support services:** Crisis diversion that is provided in the client's own home.

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)

The information listed in the left box of each category is a guideline, document observations in the right box.
If no observation occurred, mark the "Not Observed" box for that section.

A. Staff / Client Interactions **Time of Observation:** ☐ **Not Observed**

What staff instruction and supports were observed?

Staff name:

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**

What meal(s) were observed?

Any dietary restrictions?

Did the meal appear balanced and nutritious?

Were the restrictions accommodated?

☐ Yes ☐ No

C. Medication Assistance **Time of Observation:** ☐ **Not Observed**

What kind of assistance did the client require for medications?

Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble.

☐ Staff ☐ Client

How did the client take their pills?

Was the medication mixed in food? (388-101D-0310)

☐ Yes ☐ No

Was the medication crushed?

☐ Yes ☐ No

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 B - K.

☐ **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?

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**
Does anyone tell you that you can't 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**
Does anyone share your food?	
I. Social Activities / Work	☐ **Declined to Answer**
What kinds of things did you do for fun?	
J. Finances	☐ **Declined to Answer**
Does anyone tell you how you can spend your money?	

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	DATE OF RECORDS REVIEW

Finances

Does the provider manage client funds? ☐ Yes ☐ No

Signed IFP? ☐ Yes ☐ No

Guardian / Client approved? ☐ Yes ☐ No

Client finances contact / title:

Are there staff that may assist? ☐ Yes ☐ No

Are there shared expenses? ☐ Yes ☐ No

Any fees or late charges? ☐ Yes ☐ No

Any provider loans? ☐ Yes ☐ No

Mismanaged / lost / stolen funds? ☐ Yes ☐ No

Property record? ☐ Yes ☐ No

	Checking			Cash / Gift Cards			EBT			Other
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	
Ledger	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Reconciled / verified	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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	DATE OF RECORDS REVIEW

Client Characteristics

Level 5+	G	GP	AE	NEW	ND	NV	MED	PBS	RES	CP	ALARMS	IFP	GH

Diagnosis:

PCSP

Assistance Levels:	F	P	V	M	N
Taking medications	☐	☐	☐	☐	☐
Avoiding health and safety hazards	☐	☐	☐	☐	☐
Obtaining medical services	☐	☐	☐	☐	☐
Managing money	☐	☐	☐	☐	☐
Protecting self from exploitation	☐	☐	☐	☐	☐

PCSP effective date:

PCSP signed by:

Extensive medical concerns:

Extensive behavioral concerns:

IISP

IISP; date:

Functional Assessment; date:

Yes	No		Yes	No		Yes	No	
☐	☐	6-month review	☐	☐	Implementation of goals	☐	☐	Target behavior
☐	☐	Goals defined	☐	☐	Risks and interventions identified	☐	☐	Behavior function
☐	☐	IISP with methods	☐	☐	PCSP based instructions and support	☐	☐	Finalized within 45 days
☐	☐	IISP approval						

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?	☐	☐	☐

Nurse Delegation: ☐ Yes ☐ No; if yes, complete below:

Yes	No				
☐	☐	Consent (date:)	☐ Oral	☐ Topical	☐ Drops: eye / ear
☐	☐	Instructions available to staff	☐ Tube feedings	☐ Insulin	
☐	☐	90 Day Review	☐ Other:		

Observations / interviews:

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

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

CLIENT NAME	CLIENT SAMPLE ID NUMBER

PBSP

Date:

Restrictive procedures: ☐ Yes ☐ No

If yes, complete below:

Date:

	Yes	No	N/A
Client / guardian consent	☐	☐	☐
Housemate consent	☐	☐	☐

Community Protection (CP): ☐ Yes ☐ No

If yes, complete below:

Date:

	Yes	No	N/A
Treatment plan	☐	☐	☐
CP chaperone agreement	☐	☐	☐
CP Residential housing	☐	☐	☐
Mixed CP housing	☐	☐	☐
Psychosexual / CP risk assessment	☐	☐	☐

REASON FOR FUNCTIONAL ASSESSMENT (CHECK ALL THAT APPLY) ☐ N/A

☐ Self-injury ☐ Psych meds – PRN ☐ Suicide attempt ☐ Assault or injury to others ☐ Physical restraints

☐ Sexual aggression ☐ Emotional outburst ☐ Property destruction ☐ Restrictive procedures

☐ Other:

Medications

MAR Review	Yes	No	N/A
Medications noted on MAR were available in the medication supply	☐	☐	☐
Staff initials on MAR indicate medications given as prescribed for the month	☐	☐	☐
Medication list and purpose	☐	☐	☐

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

Notes:

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

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

RELEASE OF INFORMATION (ROI):

CLIENT NAME	CLIENT SAMPLE ID NUMBER

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-0215 IISP Documentation	**388-101D-0490(1)** CP client records – psychosexual / risk assessments
388-101D-0215(5) IISP Documentation (agreement)	**388-101D-0500** CP client home location
388-101D-0230 Ongoing IISP updates	**388-101-4150** Mandatory Reporting-CRU
388-101D-0355 Psychotropic Medications	**388-101-4160** Mandatory Reporting-Law Enforcement

Notes:

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 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?

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.	
How did you learn about client's needs and how to provide instruction and supports to her/him?	
B. Client Health Care and Medication	**WAC 388-101D-0185 (services), WAC 388-101D-0325 (medications)**
Tell me about client health care needs.	
What kind of medication assistance does client need?	
Are there nurse delegations for any task?	
What medical concerns are you following?	
What kinds of medications does client take?	
Where can you find information on the side effects?	
What is the process if a client refuses to take their medication?	
C. Finance / Food / Meals	**WAC 388-101D-0235**
What assistance does the client need to pay bills and buy food?	
Where is the EBT card kept?	
Who can use it?	
Who does the food shopping and how often?	
How is the food purchased, stored, and prepared?	
Do the client's share food or eat meals family style?	
Who does the cooking?	
Do you know what a healthy diet is? How do you assist the client with a healthy diet?	
D. Mandatory Reporting	**WAC 388-101-4150, WAC 388-101-4160**
What is Mandatory Reporting?	
How would you know if 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**
If the client has a Positive Behavior Support Plan, how do you access it?	
What behaviors are noted?	

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

ATTACHMENT H

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 Home Environment and Safety Worksheet

Observations of the environment occur throughout the certification evaluation process.

CLIENT NAME	CCRSS SAMPLE ID NUMBER
DATE OF OBSERVATIONS	TIME OF OBSERVATIONS

Quality of Life / Client Rights **WAC 388-101D-0170**

Y	N	N/A		Y	N	N/A	
☐	☐	☐	Was adaptive / life sustaining equipment available, clean, and in good repair?	☐	☐	☐	Was there accessible telephone equipment and list of emergency contact numbers?
☐	☐	☐	Were doors and windows unblocked?	☐	☐	☐	Were audio monitors used appropriately?
☐	☐	☐	Was the environment homelike?				

Physical Environment

Y	N	N/A		Y	N	N/A	
☐	☐	☐	Were stairs / steps, handrails / ramps, and walkways in good repair?	☐	☐	☐	Were flammable and combustible materials stored safely?
☐	☐	☐	Clear of clutter that could be potentially hazardous to the client(s)?	☐	☐	☐	Was the yard free of garbage / refuse?
☐	☐	☐	Clear of signs of unsanitary home conditions (i.e., mold, mildew, etc.)?	☐	☐	☐	Was the property free of pests?

Bathrooms

Y	N	N/A		Y	N	N/A	
☐	☐	☐	Safe and clean?	☐	☐	☐	Accessible for all clients?
☐	☐	☐	Adequate lighting?	☐	☐	☐	Private?
☐	☐	☐	Grab bars?				

Safety

Y	N	N/A		Y	N	N/A	
☐	☐	☐	Emergency food and water supply?	☐	☐	☐	Operating smoke detectors (with light alarm for clients with hearing impairments)?
☐	☐	☐	Medications locked-up?	☐	☐	☐	Cleaning supplies / toxic materials locked-up if required by clients' safety needs?
☐	☐	☐	First aid supplies available?	☐	☐	☐	Evacuation plan and practice drills?
☐	☐	☐	Working flashlight available?				
☐	☐	☐	Door / window alarms?				

Water Temperature in ºF, check in two (2) locations (if first check >120ºF, re-check water temperature)

Temperature: _____ºF ☐ Kitchen	Temperature: _____ºF ☐ Kitchen
Date / time: _____ ☐ A.M. ☐ P.M.	Date / time: _____ ☐ A.M. ☐ P.M.
Temperature: _____ºF ☐ Bedroom	Temperature: _____ºF ☐ Bedroom
Date / time: _____ ☐ A.M. ☐ P.M.	Date / time: _____ ☐ A.M. ☐ P.M.

NOTES

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

ATTACHMENT I

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 Residential Cost Report – ISS Hours Review / Questionnaire

The ISS Hours Review / Questionnaire documents a sample of the providers ISS process to determine if there are anomalies requiring more detailed review by the Developmental Disabilities Administration (DDA) and/or the Office of Rates Management.

ISS Verification

Obtain the most recent cost report Schedule B submitted by the provider from the RCS Field Manager (or designee).

Ask the provider to reconcile the gross payroll reported on Schedule B, cell N65 with the provider's internal source payroll summary records.

If the gross payroll on Schedule B matches the provider's payroll record(s) supplied (or the variance is less than 2%), complete the heading on the ISS Review / Questionnaire form and write "Gross payroll amounts match within the guidelines" in the comment section of the form.

If the Schedule B reported amount does not match the provider's payroll summary, forward the information to the RCS Field Manager (or designee), so it can be sent with copies of the working papers to the Office of Rates Management for a further ISS review.

Evaluator will submit findings to the RCS Field Manager.

The RCS Field Manager will report any material discrepancies found to Office of Rates Management, Management Services Division, and the Developmental Disabilities Administration.

Comments

Schedule B reviewed per new process effective April 2021.

Gross payroll amounts match within guidelines.

FIELD MANAGER	DATE REVIEWED

Note: Schedule B will be provided by Office of Rates Management to the RCS Field Manager prior to certification evaluations.

CCRSS PROVIDER NAME	CERTIFICATION NUMBER	RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATES

ATTACHMENT K

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 Sample / Record Review

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D							
Hire Date								
Training before working alone (IISP, emergency procedures, reporting requirements, client confidentiality)	0095							
Staff Training within four weeks (mission statement, policies, and procedures, on the job training)	0055 0100							
75 hours of basic training within 120 days - indirect supervision required until then or Exemption Letter	0087	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER
Staff Training within six months (client services, residential guidelines, positive behavior support), Bloodborne Pathogens with HIV/AIDS)	0105							
First Aid and CPR (within the first 6 month of hire and current)	0105 0110							
Nurse Delegation Training	0160							
NAR/NAC Training	0160 0315							
CP Training	0480							
Continuing Education (12 hours per calendar year)	0100							
Annual review of DSHS 10-403 (Abuse / Neglect)	0500							
THE FOLLOWING TWO QUESTIONS ARE SETTING SPECIFIC, IF N/A IS MARKED, THE ENTIRE ROW WILL BE CONSIDERED N/A, AS THIS INDICATES IT DOES NOT APPLY TO SETTING BEING REVIEWED.								
COVID (vaccine or exemption) (SOLA only) ☐ N/A								
TB Test (GTH only) ☐ N/A	0655							

CCRSS PROVIDER NAME	CERTIFICATION NUMBER	RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATES

ATTACHMENT L

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 Background Record Review

Instructions: Sample should include staff who have been hired since last certification.

Result Type Meanings: NR – No Record; RR – Review Required; D – Disqualify; A – Additional Information needed.

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D								
Hire Date									
Date WA State Name and Date of Birth (WNDOB) background check completed	0075								
WNDOB Result Type		☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A
Date of Character, Competence and Suitability Review (CCSR) following WNDOB. N/A if no record		☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
Date Final Fingerprint Check completed	0070								
Fingerprint Result Type	0070	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A
FBI Record of Arrests and Prosecutions (RAP), in employee file?		☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A
Date of CCSR following fingerprint check. N/A if no record		☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

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

ATTACHMENT J

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 Notes

CLIENT(S)	STAFF