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

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 Staff Background Check and Record Review

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
Lives out of state?		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date Final Fingerprint (FP) 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 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 FP check. N/A if no record		☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

Each box for a sampled staff should be completed or have further explanation.
Result Type Meanings: NR – No Record; RR – Review Required; D – Disqualify; A – Additional Information needed.

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RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)
CCRSS Staff Background Check and Record Review

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D								
Hire Date									
Training before working alone (IISP, emergency procedures, reporting regulation, client confidentiality)	0095								
Training within four weeks	0055, 0100								
75 hours basic training within 120 days – indirect supervision or exemption letter required until then	0055, 0100	☐ Letter	☐ Letter	☐ Letter	☐ Letter	☐ Letter	☐ Letter	☐ Letter	☐ Letter
Staff Training within six months	0105								
Bloodborne Pathogens	0090								
First Aid and CPR (within first six months and current)	0105, 0110								
Nurse Delegation Training	0160								
NAR / NAC Training	0150, 0315								
CP Training	0480								
Continuing Education (12 hours per calendar year)	0100								
Annual review of DSHS 10-403 (Abuse / Neglect)	0500								
The following question is setting specific, if N/A is marked, if the certification is not for a GTH, the entire row will be considered N/A.									
TB Test (GTH only)	0655								

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AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)
CCRSS Staff Background Check and Record Review

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D								
Hire Date									
Notes									

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

ATTACHMENT N

CCRSS Certification Evaluation
Administrator Record Review and Interview

Record Request (this checklist is a tool as to what records may be requested, boxes are not required to be checked)

☐ Staff list and location of staff records
☐ Updated Client Characteristic Roster (DSHS 10-691 optional resource for provider – they may choose to provide the same information in their format of choice)
☐ Provider insurance
☐ Organizational chart
☐ Client records in sample and location (IISP, MARs, ETR / ETPs, PBSP and FA, if applicable)
☐ Cost report

☐ Community Protection Program (CPP) site approvals (if applicable)
☐ Incident reports (previous 24 months) and location
☐ Policies and procedures
☐ Emergency and disaster plan
☐ Infection Prevention and Control procedures
☐ Other (specify):

Administrator (or Designee) Interview Questions

STAFF NAME	DATE	TIME ☐ AM ☐ PM

Are there currently any communicable disease outbreaks?

Are there any safety concerns (neighborhood safety, bed bugs, lice)?

Do any clients work for your agency?

Does the agency loan money to clients?

How do you make sure shared expenses are completed equitably/timely?

Are any agency funds combined with client funds?

How do you handle cash accounts and client credit / debit / gift cards?

Are there any stolen, lost, or damaged records?

How do you maintain property records?

Do persons who are not clients live with clients? If so, do you provide support to non-clients?

How do you notify DDA of accounts over $1700 and when clients pay for health services?

Do you support any non-CPP clients with CP Clients? If yes, is there Non-CPP client approvals?

What is your policy on staff following Mandatory Reporting?

Any irregularities (issues / theft / staff, etc.) that would be helpful for us to know about?

Who is your Resource Manager?

Verify client sample, addresses, and verify when they will be home with staff:

Will any clients be upset by our visit?

Notes

Provider Insurance

Total Number of vehicle(s) owned by provider:
Are agency vehicles insured? ☐ Yes   ☐ No (notify FM if no insurance)
Name of insurance agency: Expiration:

Agency Insurance – two million coverage or 3 million coverage for CPP providers? ☐ Yes   ☐ No (notify FM if no insurance)
Name of insurance agency: Expiration:

Infection Prevention and Control (IPC) Provider Information; explain in Notes any answer marked "No."

Are there written Infection Control Policies and Procedures to prevent the spread of infection:

	YES	NO
• Standard precautions	☐	☐
• Transmission based precautions	☐	☐
• Reference to national, state, and/or local standards	☐	☐
• Outbreak management	☐	☐

Respiratory Protection Program (only required for GH or GTH, or if in Provider Policy) ☐ N/A

	YES	NO
• Written program	☐	☐
• Medical evaluation to wear an N95 respirator	☐	☐
• Training (annual and on hire)	☐	☐
• Fit testing (initial, annual, after physical change)	☐	☐
• Record keeping (medical clearance, training, fit test results)	☐	☐

Sick Leave Policies – non-punitive, flexible, requires ill staff to stay home .... ☐ ☐

Contingency Staffing Plans – how homes are staffed during a crisis .... ☐ ☐

Staff and Client Education to prevent the spread of infection .... ☐ ☐

IPC Supplies – provider ensures:

	YES	NO
• Personal Protective Equipment (PPE) supplies in each home for clients, staff, and visitors (gowns, masks, gloves)	☐	☐
• Alcohol Based Hand Rub (ABHR) and hand hygiene products available for clients, staff, and visitors	☐	☐
• Environmental Protection Agency (EPA) registered products and cleaning of high touch areas	☐	☐

Notes

IPC Resource Links

- Standard Precautions
- Centers for Disease Control (CDC) Return to Work Guidance for Healthcare Workers
- Outbreak definition
- Respiratory Protection Program
- Washington State Local Health Departments and Districts
- ALTSA Provider / Administrator Letters

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ATTACHMENT Q

CCRSS Certification Evaluation
Exit Preparation / Exit Conference

Date: Time: ☐ AM ☐ PM   Location: ☐ Teams ☐ In provider office

☐ Administrator / Designee present (Designee's name:)

Introductions

Thank the provider and staff for everyone's cooperation during the evaluation.

The purpose of the exit conference is to provide information about any preliminary deficiencies. We may still need to gather further information following the on-site visit. If additional information is discovered after this meeting that impacts what is discussed today, we will call you prior to receiving the written report.   Any issues that arise during the exit that cannot be answered by the evaluators during the exit conference will be forwarded to the RCS FM for follow up.

Notes:

Sampled Clients

During the evaluation, we take a representative sample of clients with varying levels of needs and supports. This helps us to obtain an accurate picture of your overall performance and compliance. Identify the sampled clients

Notes:

Preliminary Deficiencies (include client / staff names or identifier, summary of the issue and WAC / RCW)

Next Steps

- Please send any requested information to evaluator(s) (provide time frame – ideal within 24 hours, no later than seven calendar days after exit)
- Explain:
  - Process and timeframes for RCS management review / approval of SOD
    - A SOD report will be sent within 10 working days of the last date of data collection (not the exit date)
  - Submission process and timelines to submit plan of correction (POC)
    - A POC is not required for consultations.
  - Provider responsibility to initiate POC, even if planning to request IDR.
  - IDR process, which will also be included on the final report.
- A follow-up **may** occur.

Notes