| CCRSS PROVIDER NAME | | | | | | | | | | CERTIFICATION NUMBER |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | | | | | | CERTIFICATION EVALUATION DATE(S) | | | | |
|  | | | | | | | | | | |
|  | | | ATTACHMENT B  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** | | | | | | | | | | |
|  | | | | | | | | | | |