|  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 [ ]  ClientDid the client receive assistance as identified in their PCSP? [ ]  Yes [ ]  NoWas the medication crushed or mixed in food (WAC 388-101D-0310)? [ ]  Yes [ ]  No |
| **D. Notes**  |
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