| CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
|  |  ATTACHMENT F AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED 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 1Date:Time:Result (i.e., left message):  | CONTACT ATTEMPT 2Date:Time: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** |
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