| 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 SERVICES  CERTIFIED 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 1  Date:Time:  Result (i.e., left message): | | | CONTACT ATTEMPT 2  Date: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** | | | | |
|  | | | | |