| A picture containing text, clipart  AI-generated content may be incorrect. |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Certification Evaluation Client Interview** |
| --- | --- |
| PROVIDER / CONTRACTOR NAME | EVALUATOR NAME |
| EVALUATION DATES | INTERVIEW DATE |
|  |
| CLIENT NAME | COMMUNICATION METHOD | CLIENT ABLE TO PARTICIPATE[ ]  Yes [ ]  No | CONSENT GIVEN TO SHARE RESPONSES[ ]  Yes [ ]  No |
| CONTACT ATTEMPTS / REASON INTERVIEW COULD NOT BE COMPELTED |
| The questions below are meant to capture if individuals are satisfied with the provider’s instruction and supports, if needs are met, and if client rights are protected. Document answers to the questions or if they decline to answer. Some questions may not be applicable, depending on the type of program the client is in (i.e. finances).  |
| **This section is for Alternative Living only:** |
| **Overall Satisfaction** | **Yes** | **No** | **N/A** | **Comments** |
| How often do you see your provider? |  |
| What goals are you working on with your provider? |  |
| Whom would you talk to if you had concerns? |  |
| Do you have a way to contact:* Adult Protective Services (or Child Protective Services)
 | [ ]  | [ ]  | [ ]  |  |
| * Your parent or guardian
 | [ ]  | [ ]  | [ ]  |
| * Case manager
 | [ ]  | [ ]  | [ ]  |
| Do you get the help that you need? | [ ]  | [ ]  | [ ]  |  |
| What do you like about the provider? | [ ]  | [ ]  | [ ]  |  |
| What could the provider do better or more of? |  |
| **Respect of Individuality, Independence, Personal Choice, Dignity** | **Yes** | **No** | **N/A** | **Comments** |
| Did you agree to the services you are receiving now? Were you able to meet the provider and agree to work with the provider? | [ ]  | [ ]  | [ ]  |  |
| **Social Activities / Work** |  |  |  | **Comments** |
| What kind of things do you do for fun? |  |
| **This section is for all other provider types:** |
| **Overall Satisfaction** | **Yes** | **No** | **N/A** | **Comments** |
| Do you like living here? | [ ]  | [ ]  | [ ]  |  |
| Is there anything you do not like about living here? | [ ]  | [ ]  | [ ]  |  |
| How often do you see your provider? |  |
| What goals are you working on with your provider? |  |
| Whom would you talk to if you had concerns? |  |
| Do you feel safe here? | [ ]  | [ ]  | [ ]  |  |
| Do you have a way to contact:* Adult Protective Services (or Child Protective Services)
 | [ ]  | [ ]  | [ ]  |  |
| * Your parent or guardian
 | [ ]  | [ ]  | [ ]  |
| * Case manager
 | [ ]  | [ ]  | [ ]  |
| Do you get the help that you need? | [ ]  | [ ]  | [ ]  |  |
| What do you like about the staff / provider? |  |
| What could the staff / provider do better or more of? |  |
| **Support of Personal Relationships** | **Yes** | **No** | **N/A** | **Comments** |
| Do you have friends or family in the community that you visit with? | [ ]  | [ ]  | [ ]  |  |
| Does the staff / provider help you make plans to see them? | [ ]  | [ ]  | [ ]  |  |
| **Restrictions** | **Yes** | **No** | **N/A** | **Comments** |
| Are there any rules in your house? If so, did you agree to them? | [ ]  | [ ]  | [ ]  |  |
| **Respect of Individuality, Independence, Personal Choice, Dignity** | **Yes** | **No** | **N/A** | **Comments** |
| Did you agree to the services you are receiving now? Were you able to meet the provider and agree to work with the provider? | [ ]  | [ ]  | [ ]  |  |
| Can you choose to lock your bedroom and bathroom doors? | [ ]  | [ ]  | [ ]  |  |
| Can you make choices about the care and services you receive here at the home? | [ ]  | [ ]  | [ ]  |  |
| **Environment** | **Yes** | **No** | **N/A** | **Comments** |
| Tell me about your room / home and how it is decorated. Did you make the choices and help? |  |
| If you have a roommate, were you informed you would have a roommate? Did they ask if it was okay with you? Could you change roommates if you wanted to? | [ ]  | [ ]  | [ ]  |  |
| **Health and Safety** | **Yes** | **No** | **N/A** | **Comments** |
| Do you see a doctor or dentist when you need to? | [ ]  | [ ]  | [ ]  |  |
| When you need help taking medications, does your provider help you? | [ ]  | [ ]  | [ ]  |  |
| **Food / Shopping** | **Yes** | **No** | **N/A** | **Comments** |
| Does anyone share your food? | [ ]  | [ ]  | [ ]  |  |
| Do you have access to food you choose at any time? | [ ]  | [ ]  | [ ]  |  |
| Who shops for the food? |  |
| What do you do to help fix the food? |  |
| **Social Activities / Work** | **Yes** | **No** | **N/A** | **Comments** |
| What kinds of things do you do for fun and relaxation? |  |
| Do you have an opportunity to participate in community activities of your choosing? | [ ]  | [ ]  | [ ]  |  |
| **Finances (if applicable)** | **Yes** | **No** | **N/A** | **Comments** |
| Do you handle your own finances or does someone help you? | [ ]  | [ ]  | [ ]  |  |
| Do you get spending money?  | [ ]  | [ ]  | [ ]  |  |
| Are you able to spend your money on things you want?  | [ ]  | [ ]  | [ ]  |  |
| FOLLOW-UP NOTES |