| CCRSS PROVIDER NAME | | | | | | | | | | | | | | | | CERTIFICATION NUMBER | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | | | | | | | | | | | | CERTIFICATION EVALUATION DATE(S) | | | | | | | | | | | | |
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|  | | ATTACHMENT E  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Record Review** | | | | | | | | | | | | | | | | | | | | | | |
| CLIENT NAME | | | | | | | | | | | | | | | | | CLIENT SAMPLE ID NUMBER | | | | | | | |
| **Client Characteristics** | | | | | | | | | | | | | | | | | | | | | | | | |
| Level 5+ | G | | VP | AE | NEW | ND | | | NV | | MED | | | PBS | RES | | | CP | | | WORK | $ | GH | CDBS / CDSS |
| Diagnoses: | | | | | | | | | | | | | | | | | | | | | | | | |
| **PCSP** | | | | | | | | | | | | | | | | | | | | | | | | |
| Effective date:  Notes: | | | | | | | | | | | | | | | | | | | | | | | | |
| **IISP** | | | | | | | | | | | | | | | | | | | | | | | | |
| IISP; date: | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes No  6-month review  Goals defined and implemented | | | | | | | | Yes No  IISP with methods  IISP approval | | | | | | | | | | | Yes No  Implementation of goals  Risk and interventions identified | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Information** | | | | | | | | | | | | | | | | | | | | **Medical Devices** | | | | |
| Physical date:  Dental date:  Follow-up on medical:  Other medical (podiatry, eye, etc.):  Protocols: | | | | | | | | | | | | | | | | | | | | Yes No N/A  Current doctors’ orders?  Consent?  Instructions / plan? | | | | |
| Notes: | | | | |
| Nurse Delegation:  Yes; (if yes, complete below)  No | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes No  Consent (date: )  Instructions available to staff  90 Day Review | | | | | | | Reason for Nurse Delegation (check all that apply) | | | | | | | | | | | | | | | | | |
| Topical  Oral  Nasal  Rectal  Drops: eye  Drops: ear  Insulin  Blood Glucose  G-Tube (date)  Other: | | | | | | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | | | |
| **PBSP and Functional Assessment** | | | | | | | | | | | | | | | | | | | | | | | | |
| PBSP Date:  N/A  Restrictive procedures:  Yes  No  If yes, complete below:  Date:  Yes No N/A  Client / guardian consent  Housemate consent | | | | | | | | | | | | Functional Assessment date: N/A  Yes No N/A  Target behavior  Behavior function  Finalized within 45 days | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Protection (CP):  Yes  No If yes, complete below: | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes No N/A  Treatment plan (date: )  CP chaperone agreement  CP site approval | | | | | | | | | | | | | Yes No N/A  Mixed CP housing (date: )  Psychosexual / CP risk assessment  Sex Offender Registration Required | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | | | |
| MAR Review  Dates of MAR:  Yes No N/A  Medications on hand match MAR  Staff initials on MAR indicate medications given as prescribed for the month  Medication list and purpose  Expired medications  Medications labeled / manufacturer’s instructions | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | | | |
| Psych Meds:  Yes  No; if yes, complete below:  Yes No  Instructions available to staff?  Monitoring side effects?  Psych med list and purpose | | | | | | | | | | Date met with prescriber:  Provider present?  Yes  No  If no, who accompanied client? | | | | | | | | | | | | | | |
| **Incident Reports** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Release of Information** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Notes** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Related WACs** | | | | | | | | | | | | | | | | | | | | | | | | |
| **388-101D-0025** Service provider responsibilities  **388-101D-0060** Policies and procedures  **388-101D-0130** Treatment of clients  **388-101D-0150** Client health services support  **388-101D-0150 (5)** Health services monitoring  **388-101D-0150(7)** Annual physical / dental  **388-101D-0155** Medical devices  **388-101D-0180** CP and other clients  **388-101D-0205** IISP  **388-101D-0210 (2)(b)** IISP Development - instruction and support  **388-101D-0215** IISP Documentation  **388-101D-0215(5)** IISP Documentation (agreement)  **388-101D-0230** Ongoing IISP updates  **388-101D-0355** Psychotropic Medications | | | | | | | | | | | | **388-101D-0370** Confidentiality of client records  **388-101D-0385** Contents of client records  **388-101D-0385(2)(d)** Health provider contact information  **388-101D-0405** When is F.A. required?  **388-101D-0410** When is PBSP required?  **388-101D-0425(2)(c**) Restrictive procedures-PBSP strategies  **388-101D-0425(3**) Restrictive procedures - termination of  **388-101D-0470(2)** CP policies and procedures - chaperone  **388-101D-0470(3)** CP policies and procedures - compliance with laws  **388-101D-0485** CP treatment plan  **388-101D-0490(1)** CP client records – psychosexual / risk assessments  **388-101D-0500** CP client home location  **388-101-4150** Mandatory Reporting-CRU  **388-101-4160** Mandatory Reporting-Law Enforcement | | | | | | | | | | | | |