| CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
|  |  ATTACHMENT A  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Face Sheet** |
| **CCRSS Provider Information** |
| DOING BUSINESS AS (DBA) | TELEPHONE (WITH AREA CODE) | FAX NUMBER (WITH AREA CODE) |
| MAILING ADDRESS | EMAIL ADDRESS |
| PHYSICAL ADDRESS |
| ADMINISTRATOR’S NAME | EVALUATION TEAM (INDICATE TEAM LEADER) |
| NUMBER OF CLIENTS SERVICE BY PROVIDER | SAMPLED CLIENTS ID NUMBERS |
| NUMBER OT TOTAL PERSONNEL EMPLOYED BY PROVIDER | SAMPLED PERSONNEL ID LETTERS |
| **Enter sample Client ID numbers for the following in the column below** | **Enter total number of clients in the column below** |
| Clients receiving **Group Home Services**:  |  |
| Clients receiving **Nurse Delegation**:  |  |
| Clients receiving **Community Protection Services**:  |  |
| Clients with **Positive Behavior Support Plans**:  |  |
| Clients **Prescribed Psychoactive Medications**:  |  |
| Clients with **Vocational / Employment Programs**:  |  |
| Clients with **Restrictive Procedure\***:  |  |
| Clients **Performing Work for the Provider Requiring Remuneration**:  |  |
| Clients Assessed at **Level 5+**:  |  |
| Clients whose **Funds are Managed by Agency**:  |  |
| Clients receiving **Crisis Diversion Bed Services\*\***:  |  |
| Clients receiving **Crisis Diversion Support Services\*\*\***:  |  |
| Total number of **Vehicle(s) Operated by Provider**:  | Insured? [ ]  Yes [ ]  NoIf yes, insurance company name (notify FM if no insurance): |
| Other information gathered:  |
| Alternate office sites:  |
| \* **Restrictive procedure**: Any procedure that restricts a client’s freedom of movement, access to client property, requires a client to do something, which s/he does not want to do, or removes something the client owns or has earned. Examples: locked sharps, window / door alarms, locked food, etc.\*\* **Crisis diversion bed services:** Crisis diversion that is provided in a residence maintained by the service provider.\*\*\* **Crisis diversion support services:**  Crisis diversion that is provided in the client’s own home. |
| Text  Description automatically generated |  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) |
| The information listed in the left box of each category is a guideline, document observations in the right box.**If no observation occurred, mark the “Not Observed” box for that section.** |
| **A. Staff / Client Interactions Time of Observation:       [ ]  Not Observed**  |
| What staff instruction and supports were observed?Staff name:  |
| 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**  |
| What meal(s) were observed? |
| Any dietary restrictions? |
| Did the meal appear balanced and nutritious? |
| Were the restrictions accommodated?[ ]  Yes [ ]  No |
| **C. Medication Assistance Time of Observation:       [ ]  Not Observed**  |
| What kind of assistance did the client require for medications? |
| Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble.[ ]  Staff [ ]  Client |
| How did the client take their pills? |
| Was the medication mixed in food? (388-101D-0310)[ ]  Yes [ ]  No |
| Was the medication crushed?[ ]  Yes [ ]  No |
| Text  Description automatically generated |  ATTACHMENT C AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Interview** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF CLIENT INTERVIEW | TIME OF CLIENT INTERVIEW |
| Document client answers to the questions or declination to answer the questions on the right side of the box. Ask at least one question or a related question for Section B - K. [ ]  **Check here if the client is not capable of being interviewed.** [ ]  **Check here if the client declined the entire interview.** |
| **If a box above is checked, skip rest of form, and move to next form.** |
| **The following are REQUIRED questions and MUST be asked during the interview. Check “Y,” if the answer is yes; check “N,” if answer is no and document the interviewee’s response; or check “D,” if the interviewee declined to answer the question; or check “N/A” if the question was not asked because it does not apply to that client (i.e., client does not have a roommate). The questions in this section were developed with CMS as part of a waiver and CANNOT be modified.** |
|  Y N D N/A[ ]  [ ]  [ ]  [ ]  Can you make choices about the care and services you receive here at the home?[ ]  [ ]  [ ]  [ ]  If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to?[ ]  [ ]  [ ]  [ ]  Do you have an opportunity to participate in community activities? |  Y N D N/A[ ]  [ ]  [ ]  [ ]  Can you choose who visits you and when?[ ]  [ ]  [ ]  [ ]  Do they pay attention to what you have to say?[ ]  [ ]  [ ]  [ ]  Can you choose to lock your door?[ ]  [ ]  [ ]  [ ]  Do you have access to food anytime?[ ]  [ ]  [ ]  [ ]  Do you receive services in the community? |
| **A. Overall Satisfaction and Responses to Concerns** **[ ]  Declined to Answer** |
| What do you like about living here?  |
| **B. Care and Service Needs [ ]  Declined to Answer** |
| Do you get the help that you need? |
| **C. Support of Personal Relationships [ ]  Declined to Answer** |
| Do you have friends or relatives in the community that you visit with?  |
| **D. Restrictions [ ]  Declined to Answer** |
| Does anyone tell you that you can’t do things you want to do?  |
| **E. Respect of Individuality, Independence, Personal Choice, Dignity (meals, activities, money) [ ]  Declined to Answer** |
| Can you make your own choices?  |
| **F. Environment [ ]  Declined to Answer** |
| Tell me about your room is decorated and did you help?  |
| **G. Health and Safety [ ]  Declined to Answer** |
| Do you feel safe here?  |
| **H. Food / Shopping / Preferences [ ]  Declined to Answer** |
| Does anyone share your food?  |
| **I. Social Activities / Work [ ]  Declined to Answer** |
| What kinds of things did you do for fun?  |
| **J. Finances [ ]  Declined to Answer** |
| Does anyone tell you how you can spend your money?  |
| Text  Description automatically generated |  ATTACHMENT D AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Finances Record Review** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER | DATE OF RECORDS REVIEW |
| **Finances** |
| Does the provider manage client funds? [ ]  Yes [ ]  No Signed IFP? [ ]  Yes [ ]  No Guardian / Client approved? [ ]  Yes [ ]  No Client finances contact / title:  |
| Are there staff that may assist? [ ]  Yes [ ]  No  |
| Are there shared expenses? [ ]  Yes [ ]  No  |
| Any fees or late charges? [ ]  Yes [ ]  No  |
| Any provider loans? [ ]  Yes [ ]  No  |
| Mismanaged / lost / stolen funds? [ ]  Yes [ ]  No  |
| Property record? [ ]  Yes [ ]  No  |
|  **Checking Cash / Gift Cards EBT Other** |
|  | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |  |
| Ledger | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Reconciled / verified | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Receipts over $25 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Running balance | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **WACs:** 388-101-3020 (Compliance)388-101D-0235 (Shared expenses and client related funds)388-101D-0240(1,6,9) (Individual financial plan)388-101D-0245(8) (Managing client funds) | 388-101D-0255 (Reconciling and verifying client accounts)388-101D-0270 (Client financial records)388-101D-0285 (Client reimbursement)388-101D-0390 (Client’s property record) |
| **Notes** |
|  |
| Text  Description automatically generated |  ATTACHMENT E AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Record Review** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER | DATE OF RECORDS REVIEW |
| **Client Characteristics** |
| Level 5+ | G | GP | AE | NEW | ND | NV | MED | PBS | RES | CP | ALARMS | IFP | GH |
| Diagnosis:  |
| **PCSP** |
| Assistance Levels: | F | P | V | M | N | PCSP effective date: PCSP signed by:  |
| Taking medications | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Avoiding health and safety hazards | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Obtaining medical services | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Managing money | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Protecting self from exploitation | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Extensive medical concerns:  |
| Extensive behavioral concerns:  |
| **IISP** |
| IISP; date:  | Functional Assessment; date:  |
| Yes No [ ]  [ ]  6-month review [ ]  [ ]  Goals defined [ ]  [ ]  IISP with methods [ ]  [ ]  IISP approval | Yes No [ ]  [ ]  Implementation of goals [ ]  [ ]  Risks and interventions identified [ ]  [ ]  PCSP based instructions and support | Yes No [ ]  [ ]  Target behavior [ ]  [ ]  Behavior function [ ]  [ ]  Finalized within 45 days |
| **Medical Information** | **Medical Devices** |
| Physical date:  | Dental date:  |  Yes No N/ACurrent doctors’ orders? [ ]  [ ]  [ ] Consent? [ ]  [ ]  [ ] Instructions / plan? [ ]  [ ]  [ ]  |
| FOLLOW-UP ON MEDICAL |
| OTHER MEDICAL (PODIATRY / EYE / ETC.) |
| PROTOCOLS |
| Nurse Delegation: [ ]  Yes [ ]  No; if yes, complete below:Yes No [ ]  [ ]  Consent (date: ) [ ]  [ ]  Instructions available to staff [ ]  [ ]  90 Day Review | [ ]  Oral [ ]  Topical [ ]  Drops: eye / ear[ ]  Tube feedings [ ]  Insulin[ ]  Other:  |
| Observations / interviews:  |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| **PBSP** |
| Date: Restrictive procedures: [ ]  Yes [ ]  No If yes, complete below:Date: Yes No N/AClient / guardian consent [ ]  [ ]  [ ] Housemate consent [ ]  [ ]  [ ]   | Community Protection (CP): [ ]  Yes [ ]  No If yes, complete below:Date: Yes No N/ATreatment plan [ ]  [ ]  [ ] CP chaperone agreement [ ]  [ ]  [ ] CP Residential housing [ ]  [ ]  [ ] Mixed CP housing [ ]  [ ]  [ ] Psychosexual / CP risk assessment [ ]  [ ]  [ ]  |
| REASON FOR FUNCTIONAL ASSESSMENT (CHECK ALL THAT APPLY) [ ]  N/A[ ]  Self-injury [ ]  Psych meds – PRN [ ]  Suicide attempt [ ]  Assault or injury to others [ ]  Physical[ ]  Sexual aggression [ ]  Emotional outburst [ ]  Property destruction [ ]  Restrictive procedures restraints[ ]  Other:   |
| **Medications** |
| MAR Review Yes No N/AMedications noted on MAR were available in the medication supply [ ]  [ ]  [ ] Staff initials on MAR indicate medications given as prescribed for the month [ ]  [ ]  [ ] Medication list and purpose [ ]  [ ]  [ ]  |
| Psych Meds: [ ]  Yes [ ]  No; if yes, complete below: Yes NoInstructions available to staff? [ ]  [ ] Monitoring side effects? [ ]  [ ] Psych med list and purpose [ ]  [ ]  | Date met with prescriber: Provider present? [ ]  Yes [ ]  NoIf no, who accompanied client?  |
| **Incident Reports** |
| Notes: |
| RELEASE OF INFORMATION (ROI): |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| **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 |
| Notes: |
|  |  ATTACHMENT F AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICESCERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Family / Representative /  Collateral Contact Interview** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF INTERVIEW | TIME OF INTERVIEW |
| [ ]  If interview is not with a court-appointed guardian, check here if the client did not give permission for a collateral interview. If the box is checked, skip rest of form, and move on. |
| CONTACT NAME AND NUMBER | RELATIONSHIP TO CLIENT |
| CONTACT ATTEMPTS |
| 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? |
| Text  Description automatically generated |  ATTACHMENT G AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Staff Interview** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER | DATE OF INTERVIEW |
| STAFF NAME | STAFF SAMPLE ID NUMBER | TIME OF INTERVIEW |
| **A. Client Needs**  |
| Tell me about the instruction and supports that you provide to client. |  |
| How did you learn about client’sneeds and how to provide instruction and supports to her/him? |  |
| **B. Client Health Care and Medication** [**WAC 388-101D-0185**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0185) **(services),** [**WAC 388-101D-0325**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0325) **(medications)** |
| Tell me about clienthealth care needs. |  |
| What kind of medication assistance does clientneed? |  |
| Are there nurse delegations for any task? |  |
| What medical concerns are you following? |  |
| What kinds of medications does clienttake? |  |
| Where can you find information on the side effects? |  |
| What is the process if a client refuses to take their medication? |  |
| **C. Finance / Food / Meals** [**WAC 388-101D-0235**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0235) |
| What assistance does the client need to pay bills and buy food? |  |
| Where is the EBT card kept? |  |
| Who can use it? |  |
| Who does the food shopping and how often? |  |
| How is the food purchased, stored, and prepared? |  |
| Do the client’s share food or eat meals family style? |  |
| Who does the cooking? |  |
| Do you know what a healthy diet is? How do you assist the client with a healthy diet? |  |
| **D. Mandatory Reporting** [**WAC 388-101-4150**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101-4150)**,** [**WAC 388-101-4160**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101-4160) |
| What is Mandatory Reporting? |  |
| How would you know if a client was being abused, neglected, or financially exploited? |  |
| **E. Positive Behavior Support Plan** [**WAC 388-101D-0400**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0400)**,** [**WAC 388-101D-0405**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0405)**,** [**WAC 388-101D-0410**](https://app.leg.wa.gov/WAC/default.aspx?cite=388-101D-0410) |
| If the clienthas a Positive Behavior Support Plan, how do you access it? |  |
| What behaviors are noted? |  |
|  |  ATTACHMENT H AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Home Environment and Safety Worksheet** |
| Observations of the environment occur throughout the certification evaluation process. |
| CLIENT NAME | CCRSS SAMPLE ID NUMBER |
| DATE OF OBSERVATIONS | TIME OF OBSERVATIONS |
| **Quality of Life / Client Rights WAC 388-101D-0170** |
| Y N N/A[ ]  [ ]  [ ]  Was adaptive / life sustaining equipment available, clean, and in good repair?[ ]  [ ]  [ ]  Were doors and windows unblocked?[ ]  [ ]  [ ]  Was the environment homelike? | Y N N/A[ ]  [ ]  [ ]  Was there accessible telephone equipment and list of emergency contact numbers?[ ]  [ ]  [ ]  Were audio monitors used appropriately? |
| **Physical Environment** |
| Y N N/A[ ]  [ ]  [ ]  Were stairs / steps, handrails / ramps, and walkways in good repair?[ ]  [ ]  [ ]  Clear of clutter that could be potentially hazardous to the client(s)?[ ]  [ ]  [ ]  Clear of signs of unsanitary home conditions (i.e., mold, mildew, etc.)? | Y N N/A[ ]  [ ]  [ ]  Were flammable and combustible materials stored safely?[ ]  [ ]  [ ]  Was the yard free of garbage / refuse?[ ]  [ ]  [ ]  Was the property free of pests? |
| **Bathrooms** |
| Y N N/A[ ]  [ ]  [ ]  Safe and clean?[ ]  [ ]  [ ]  Adequate lighting?[ ]  [ ]  [ ]  Grab bars? | Y N N/A[ ]  [ ]  [ ]  Accessible for all clients?[ ]  [ ]  [ ]  Private? |
| **Safety** |
| Y N N/A[ ]  [ ]  [ ]  Emergency food and water supply?[ ]  [ ]  [ ]  Medications locked-up?[ ]  [ ]  [ ]  First aid supplies available?[ ]  [ ]  [ ]  Working flashlight available?[ ]  [ ]  [ ]  Door / window alarms? | Y N N/A[ ]  [ ]  [ ]  Operating smoke detectors (with light alarm for clients with hearing impairments)?[ ]  [ ]  [ ]  Cleaning supplies / toxic materials locked-up if required by clients’ safety needs?[ ]  [ ]  [ ]  Evacuation plan and practice drills? |
| **Water Temperature in oF, check in two (2) locations (if first check >120oF, re-check water temperature)** |
| Temperature:  oF [ ]  KitchenDate / time:  [ ]  A.M. [ ]  P.M. | Temperature:  oF [ ]  KitchenDate / time:  [ ]  A.M. [ ]  P.M.  |
| Temperature:  oF [ ]  BedroomDate / time:  [ ]  A.M. [ ]  P.M. | Temperature:  oF [ ]  BedroomDate / time:  [ ]  A.M. [ ]  P.M. |
| NOTES |
| Text  Description automatically generated |  ATTACHMENT I AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS** **Residential Cost Report – ISS Hours Review / Questionnaire** |
| The ISS Hours Review / Questionnaire documents a sample of the providers ISS process to determine if there are anomalies requiring more detailed review by the Developmental Disabilities Administration (DDA) and/or the Office of Rates Management. |
| **ISS Verification** |
| Obtain the most recent cost report Schedule B submitted by the provider from the RCS Field Manager (or designee).Ask the provider to reconcile the gross payroll reported on Schedule B, cell N65 with the provider’s internal source payroll summary records. If the gross payroll on Schedule B matches the provider’s payroll record(s) supplied (or the variance is less than 2%), complete the heading on the ISS Review / Questionnaire form and write “Gross payroll amounts match within the guidelines” in the comment section of the form.If the Schedule B reported amount does not match the provider’s payroll summary, forward the information to the RCS Field Manager (or designee), so it can be sent with copies of the working papers to the Office of Rates Management for a further ISS review. Evaluator will submit findings to the RCS Field Manager.The RCS Field Manager will report any material discrepancies found to Office of Rates Management, Management Services Division, and the Developmental Disabilities Administration. |
| **Comments** |
| Schedule B reviewed per new process effective April 2021.Gross payroll amounts match within guidelines. |
| FIELD MANAGER | DATE REVIEWED |
| **Note:** Schedule B will be provided by Office of Rates Management to the RCS Field Manager prior to certification evaluations. |

| CCRSS PROVIDER NAME | CERTIFICATION NUMBER | RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATES |
| --- | --- | --- | --- |
| Text  Description automatically generated |  ATTACHMENT K AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Staff Sample / Record Review**  |
|  |
| Staff Identifier | **WACs** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** |
| Name | 388-101D |  |  |  |  |  |  |  |
| Hire Date |  |  |  |  |  |  |  |
| Training before working alone (IISP, emergency procedures, reporting requirements, client confidentiality) | 0095 |  |  |  |  |  |  |  |
| Staff Training within four weeks(mission statement, policies, and procedures, on the job training) | 00550100 |  |  |  |  |  |  |  |
| 75 hours of basic training within 120 days - indirect supervision required until then or Exemption Letter | 0087 | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER | [ ]  EXEMPTION LETTER |
| Staff Training within six months (client services, residential guidelines, positive behavior support), Bloodborne Pathogens with HIV/AIDS) | 0105 |  |  |  |  |  |  |  |
| First Aid and CPR (within the first 6 month of hire and current) | 01050110 |  |  |  |  |  |  |  |
| Nurse Delegation Training | 0160 |  |  |  |  |  |  |  |
| NAR/NAC Training | 01600315 |  |  |  |  |  |  |  |
| CP Training | 0480 |  |  |  |  |  |  |  |
| Continuing Education (12 hours per calendar year) | 0100 |  |  |  |  |  |  |  |
| Annual review of DSHS 10-403 (Abuse / Neglect) | 0500 |  |  |  |  |  |  |  |
| **THE FOLLOWING TWO QUESTIONS ARE SETTING SPECIFIC, IF N/A IS MARKED, THE ENTIRE ROW WILL BE CONSIDERED N/A, AS THIS INDICATES IT DOES NOT APPLY TO SETTING BEING REVIEWED.** |
| COVID (vaccine or exemption) (SOLA only) [ ]  N/A |  |  |  |  |  |  |  |  |
| TB Test (GTH only) [ ]  N/A | 0655 |  |  |  |  |  |  |  |
| Text  Description automatically generated |  ATTACHMENT L AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Background Record Review**  |
| Instructions: Sample should include staff who have been hired since last certification.Result Type Meanings: NR – No Record; RR – Review Required; D – Disqualify; A – Additional Information needed. |
|  |
| Staff Identifier | **WACs** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** | **STAFF** |
| Name | 388-101D |  |  |  |  |  |  |  |  |
| Hire Date |  |  |  |  |  |  |  |  |
| Date WA State Name and Date of Birth (WNDOB) background check completed | 0075 |  |  |  |  |  |  |  |  |
| WNDOB Result Type |  | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A | [ ]  NR[ ]  RR[ ]  D[ ]  A |
| Date of Character, Competence and Suitability Review (CCSR) following WNDOB.N/A if no record  |  |  |  |  |  |  |  |  |  |
| [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A |
| Date Final Fingerprint Check completed | 0070 |  |  |  |  |  |  |  |  |
| Fingerprint Result Type | 0070 | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A | [ ]  NR[ ]  RR[ ]  D[ ]  A[ ]  N/A |
| FBI Record of Arrests and Prosecutions (RAP), in employee file?  |  | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A | [ ]  Yes[ ]  NO[ ]  N/A |
| Date of CCSR following fingerprint check. N/A if no record |  |  |  |  |  |  |  |  |  |
| [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A | [ ]  N/A |

| CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
| Text  Description automatically generated |  ATTACHMENT J AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Notes** |
| CLIENT(S) | STAFF |
|  |