DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Staffed Residential
Cost of Care Adjustment Request

DATE FORM COMPLETED

NAME OF CLIENT RESIDING OUT OF HOME	PROVIDER NAME PER CONTRACT	NAME OF HOUSE WHERE CLIENT RESIDES

STREET ADDRESS	CITY	STATE	ZIP CODE

A. Rate

Cost of care adjustment amount (as identified in current Exhibit B contract amendment). Total Rate per Day: $_____

B. Persons Remaining at Address

NAMES OF PERSON(S) REMAINING AT ADDRESS ABOVE	AGENCY SUPPORTED BY (CA OR DDA)

C. Adjustments

TEMPORARY ABSENCE IN (check one of the following):

☐ Medical Facility ☐ Detention/Jail ☐ RHC ☐ State Facility (such as CSTC)

☐ Other (describe):

DATES ADJUSTMENT REQUESTED:	DATE CLIENT LEAVES	DATE CLIENT RETURNS	TOTAL DAYS CLIENT IS OUT OF LICENSED SETTING:

SUBMITTED BY (NAME OF AGENCY STAFF COMPLETING THIS FORM)	DATE

D. Justification

IDENTIFY JUSTICATION FOR REQUEST

For Office Use Only
E. Cost of Care Adjustment

CLIENT(S) ASSIGNED FOR COCA AUTHORIZATION	ADSA ID	NO. OF DAYS	TOTAL RATE	ESTIMATED TOTAL COST	SERVICE CODE (STATE ONLY)	PROVIDER ONE ID
			$	$		
			$	$		
			TOTAL	$		

☐ Approve ☐ Deny; Reason for denial:

DDA VOLUNTARY PLACEMENT COORDINATOR'S SIGNATURE	DATE

☐ Approve ☐ Deny; Reason for denial:

DDA CHILDREN'S RESIDENTIAL SERVICES PROGRAM MANAGER'S (OR DESIGNEE) SIGNATURE	DATE

DISTRIBUTION: Provider, Client File, Contract File, DDA Resource Administrator, HQ Children's Residential Program Manager