Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Staffed Residential Home
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	PROVIDER SUPPORTED BY (DDA OR DCYF)

C. Adjustments

TEMPORARY ABSENCE IN (check one of the following):

☐ Medical Facility ☐ Detention/Jail ☐ RHC ☐ Inpatient Treatment Facility

☐ Other (describe):

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

D. Justification

IDENTIFY JUSTICATION FOR REQUEST

SUBMITTED BY (NAME OF STAFF COMPLETING THIS FORM)	DATE

For DDA 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 OUT-OF-HOME SERVICES COORDINATOR'S SIGNATURE	DATE

☐ Approve ☐ Deny; Reason for denial:

DDA CHILDREN'S RESIDENTIAL SERVICES PROGRAM MANAGER'S SIGNATURE (IF GREATER THAN 15 DAYS PER DDA POLICY 6.22)	DATE

DISTRIBUTION: Provider; Client File; Contract File; HQ Children's Residential Program Manager