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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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) | | | | | | | |
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| **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 | | | |