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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 |