DEVELOPMENTAL DISABILITIES ADMINISTRATION
COST OF CARE ADJUSTMENT REQUEST

A. Name of Client out of home

Client's Daily Rate who is out of the home

B. NAMES of PERSONS REMAINING at ADDRESS:

HOUSEMATE NAMES

C. ADJUSTMENT

REASON FOR TEMPORARY ABSENCE (check all that apply)
- [ ] Admitted to Medical Facility
- [ ] Admitted to Nursing Home
- [ ] In Jail
- [ ] Social Leave
- [ ] RHC Respite
- [ ] Death (date): [ ] Other (describe):

DATES ADJUSTMENT REQUESTED:
- Date Out of Home: [ ]
- End Date (not to exceed 15 days): [ ]
- Total Number of Days: [ ]
- [ ] RM check to confirm does not exceed daily rate

Total Amount Requested per Day (shared household up to full daily rate, SPH admin only):

D. EXPLANATION of why remaining household members need the rate of absent client or why administrative rate is needed for SPH

E. EXPLANATION of why STAFF ADD ON units are needed to support client that left and is now in a different setting

UNITS REQUESTED

JUSTIFICATION

SUBMITTED BY (print):

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F. COST OF CARE ADJUSTMENT

CLIENT ASSIGNED FOR COCA AUTHORIZATION

UNITS REQUESTED

G. STAFF ADD ON

CLIENT REQUIRING STAFF ADD ON UNITS

RESOURCE MANAGER COMMENTS:

- [ ] Approval Recommended
- [ ] Denial Recommended

Reason for Denial:

DDA RESOURCE MANAGER REVIEWING:

DATE:

DDA RESOURCE MANAGEMENT ADMINISTRATOR OR DESIGNEE SIGNATURE:

DATE:

DISTRIBUTION:
- Resource Manager Contracts file
- PROVIDER
- DDA Rates Analyst

DHS 06-124 (REV. 02/2019)
Cost of Care Adjustment Request (COCA) Instructions for shared household

A Cost of Care Adjustment (COCA) Request (DSHS form 06-124 per DDA Policy 6.02) is to be submitted by the residential agency in Excel format within 10 business days of the request end date. Cost of Care Adjustment is intended to cover the necessary costs to maintain uninterrupted services due to the loss of economies of scale to clients remaining in the home when there is a temporary absence of a household member.

Note: all items in red font will auto populate from other entries.

Section A Client Information
Name of the client who is out of the home temporarily.
Specify the provider name.
Date the request is being submitted to your assigned Resource Manager.
Check the program type SL for Supported Living, GH for Group Home, GTH for Group Training Home. Type in the daily rate per the contract for the time period of the request for the client who is out of the home. Refer to the Exhibit C for details as clients may have multiple rate changes throughout the year.
Type in the provider number.

Section B Names of Persons Remaining at the Address
Type in the name of the remaining household members impacted by the absence.

Section C Adjustments
Check the box that applies to the temporary absence; if reason is “death” type in the date the client died.
Check “other” and describe if none of the other options are appropriate.
Type in the dates of the requested adjustment. The total number of days will be auto-populated.
If the absence crosses a calendar month record the days of the first month on the first line and then list the dates of the second month if applicable on the second line.

You may request up to the total daily rate. This can be found in Exhibit C in your contract on column V.

Section D Justification for remaining household members
Include a justification that supports the need to maintain the support of the remaining housemates due to the loss of economies of scale.

Section E Explanation of needed support to client who left. (complete only if requesting staff add on)
List the units requested for the time period of the request.
If the need crosses a calendar month record the units of the first month in the first blank on line 23 and the units of the second month, if applicable on the second blank on line 23.
Select the client’s urban designation from the drop down.
Provide an explanation of the circumstances requiring the need for additional staff and the anticipated length of the need, including an explanation of how the amount was determined. (i.e. units the same each day or do the units vary depending on the day, weekends vs. weekdays). If situation is emergent include the name of the DDA staff you contacted and the date you contacted them.

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RM will check the applicable Exhibit C to confirm the Rate does not exceed the daily rate for the absent client.

Section F cost of care adjustment
Select a client from the list in section B.
Number of days, total rate authorized and max total cost will auto populate from section C.
Fill in the calendar month
Select the service code based on waiver or state only funding.

Section G staff add on
List absent client, month, and number of units authorized.
Select from the drop down, based on urban designation either Non-MSA $23, MSA-$24 or King-$25.
Total rate will auto populate.
Select the service code based on waiver or state only funding. If client is at a Medicaid funded program this will be state only.
Cost of Care Adjustment Request (COCA) Instructions for single person household

A Cost of Care Adjustment (COCA) Request (DSHS form 06-124 per DDA Policy 6.02) is to be submitted by the residential agency in Excel format within 10 business days of the request end date. Cost of Care Adjustment for single person households is intended to cover the administrative costs while a client who lives alone is away from the home. If the person is in a Medicaid funded facility this cost will be paid by state only funding.

Note: all items in red font will auto populate from other entries.

Section A Client Information
Name of the client who is out of the home temporarily.
Specify the provider name.
Date the request is being submitted to your assigned Resource Manager.
Check the program type SL for Supported Living.
Type in the daily rate per the contract for the time period of the request for the client who is out of the home. Refer to the Exhibit C for details as clients may have multiple rate changes throughout the year.
Type in the provider number.
check the box for SPH

Section B Names of Persons Remaining at the Address
do not complete this section

Section C Adjustments
Check the box that applies to the temporary absence.
Check “other” and describe if none of the other options are appropriate.
Type in the dates of the requested adjustment. The total number of days will be auto-populated.
If the absence crosses a calendar month record the days of the first month on the first line and then list the dates of the second month if applicable on the second line.
You may request administrative rate only. This can be found in Exhibit C in your contract on column U. This will be paid with State only funds.

Section D Justification why administrative rate is needed
include an explanation that the administrative rate is needed to maintain client household and staffing while the

Section E Explanation of needed support to client who left. (complete only if requesting staff add on)
List the units requested for the time period of the request.
If the need crosses a calendar month record the units of the first month in the first blank on line 23 and the units of the second month, if applicable on the second blank on line 23.
Select the client’s urban designation from the drop down.
Provide an explanation of the circumstances requiring the need for additional staff and the anticipated length of the need, including an explanation of how the amount was determined. (i.e. units the same each day or do the units vary depending on the day, weekends vs. weekdays). If situation is emergent include the name of the DDA staff you contacted and the date you contacted them.

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Section C
RM will check the applicable Exhibit C to confirm the Rate does not exceed the daily rate for the absent client.

Section F Cost of care adjustment
Enter absent client’s name.
Number of days, total rate authorized and max total cost will auto populate from section C.
Fill in the calendar month
Select the service code based on waiver or state only funding. If client is at a Medicaid funded program this will be

Section G Staff add on
List absent client, month, and number of units authorized.
Select from the drop down, based on urban designation either Non-MSA $23, MSA-$24 or King-$25.
Total rate will auto populate.