

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS / OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES  
CHILDREN'S CHOICE PLAN OF CARE (POC) REVISION REQUEST**

Revision #: \_\_\_\_\_  
 Participant Name: \_\_\_\_\_ Medicaid#: \_\_\_\_\_ POC Begin Date: \_\_\_\_\_ POC End Date: \_\_\_\_\_  
 Support Coordination Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Type of Revision:  Routine  Emergency Date Revision Request Submitted to Waiver Office: \_\_\_\_\_ Date of Participant Request: \_\_\_\_\_  
 Revision For: \_\_\_\_\_

Provider's Full Name	Provider #	Service Type	Procedure Code	Monthly	# of Units (Not Hours)	Cost per Unit	Yearly Cost <sup>1</sup>	Admin fees <sup>2</sup>	Requested Start Date	End Date
		Support Coordination	9E001	\$125.00	12		\$1500.00			
		Self-Direction Family supports Administrative Fee	S5125	Monthly fee						
		PSH- Housing Stabilization	Z0648							
							yearly totals <sup>Ⓢ</sup>	yearly totals <sup>Ⓢ</sup>		
Please submit current Children's Choice Services Balance report with all revisions to Plan of Care. Subtract annual services cost to determine remaining available budget. Total cost of all combined services <sup>1</sup> and Admin fees <sup>2</sup> cannot exceed \$16,410 per POC year.									Grand Total	

Support Coordinator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Individual/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 Children's Choice Provider Signature of Agreement to Deliver above Listed Services and understanding that services cannot begin or be reimbursed until PA is issued.  
 \_\_\_\_\_ Date: \_\_\_\_\_

OCDD Authority/District Waiver Office Signature: \_\_\_\_\_ Received: \_\_\_\_\_ Approved: \_\_\_\_\_ Denied: \_\_\_\_\_  
 Effective: \_\_\_\_\_

This POC budget sheet supersedes all previously OCDD approved budget sheets issued for this participant from the initial, through and up to this approved dated request.