Personal Care (PC) Service Plan

Copy to:	Provider	Date sent:	OKDHS	Date sent:
	Client	Date sent:	File	Date sent:

Client name				Case number
Street address	City	County	State	Zip

Unique ID number	Area code	Phone	County office

Services. One unit is 15 minutes.

Type of service	Provider	Hours per week	Units per week	Duties or tasks
Personal care				See Form 02AG029E

Other services. Service Authorization Model (SAM).

Type of service	Provider	Visits	Duties or tasks
SAM visit		Up to five per year	
Other:			

I accept the service plan: Yes ☐ No ☐

Date | Area nurse/designee signature

Client signature | Witness signature

Agency nurse/OKDHS nurse signature | Witness signature

Service plan period (one year)	
Effective date	End date

Certification period (up to 36 months)	
Effective date	End date

Comments/concerns: