

State of Oklahoma
Department of Human Services

Personal Care Plan

Copy to: <input type="checkbox"/> Provider <input type="checkbox"/> Client <input type="checkbox"/> File	Date sent: _____ _____ _____
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Client name	Last	First	MI
Case number		Unique identification number	

OKDHS nurse signature Date

Long-term goal:

Challenges

-
-
-

Strengths

-
-
-

Client name	Last	First	MI	Case number
Objectives	Action steps	Expected outcomes	Follow-up comments	

Client name		Last		First	MI	Case number
Objectives		Action steps		Expected outcomes		Follow-up comments

Client/legal representative signature

Date

Client name		Last		First	MI	Case number
Objectives		Action steps		Expected outcomes		Follow-up comments

Client name		Last	First	MI	Case number
Objectives	Action steps	Expected outcomes	Follow-up comments		

Client/legal representative signature

Date

Nurse signature

Date