



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Personal Care (PC) Service Plan

Copy to: Provider <input type="checkbox"/>	Date sent: _____	OKDHS <input type="checkbox"/>	Date sent: _____
Client <input type="checkbox"/>	Date sent: _____	File <input type="checkbox"/>	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: