OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Personal Care Provider Communication

Copy to: ☐ Provider Date sent:_____ ☐ File Date sent:_____

A. Identifying information.

Client name	Case number
Address	
Provider	Phone of client

B. Provider changes recommended. Check appropriate change code.

☐ IS - Increase service ☐ DS - Decrease service ☐ D - Discharge
☐ AC - Agency closure ☐ T - Terminate Personal Care services
☐ S - Suspension ☐ RS - Resume service

Number of current units per month: _____ Recommended units per month: _____
Recommended date of change: _____

Justification:

_____ _____
Completed by (signature and title) Date

_____ _____
Agency name Agency phone number

C. OKDHS nurse recommendation.

☐ Change plan: Increase service units (month) _____ Terminate service: ☐ Yes
Decrease service units (month) _____ Effective date: _____
☐ Continue present plan ☐ Other _____

Comments:

_____ _____
OKDHS nurse Date

Phone number: _____ FAX: _____

D. OKDHS area nurse. ☐ Approved ☐ Denied Effective date: _____

Comments:

_____ _____
OKDHS area nurse Date