



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF SPECIAL HEALTH CARE NEEDS
PHYSICAL DISABILITIES WAIVER PLAN OF CARE

RECIPIENT NAME	DCN
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PROVIDER NAME	DESCRIPTION	FREQUENCY	FISCAL YEAR												TOTAL UNITS	UNIT RATE	FISCAL YEAR COST PER SERVICE
			YEAR						YEAR								
			07	08	09	10	11	12	01	02	03	04	05	06			

OTHER SERVICE NEEDS (SEE CLIENT ASSESSMENT FOR FULL SERVICE NEEDS)

SERVICE COORDINATOR SIGNATURE	DATE	PDW PROGRAM MANAGER SIGNATURE	DATE
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