10A NCAC 06D .0204 CARE PLANNING

The purpose of the care plan is to identify the course of action to be followed:

(1) Care plans for an eligible client shall be developed within 12 working days of the initial screening.

(2) The care plan shall include, at a minimum, the following information:

(a) Outcome oriented goal statements and conditions for case closure;

(b) Both formal and informal services to be provided;

(c) Agencies responsible for service provision;

(d) Frequency of service provision;

(e) Duration of service provision;

(f) Signature of the client or designated representative indicating agreement with the care plan;

(g) Signature of the Registered Nurse and the Social Worker developing the care plan;

(h) Date of care plan development.

(3) Care plans shall be reviewed at least quarterly or more frequently as the client's condition warrants by both the Social Worker and the Registered Nurse based upon factors specified in Rule .0203(b) of this Section.

(4) All changes to the care plan must be documented and dated on the care plan by the Social Worker and Registered Nurse, or both.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.