10A NCAC 70J .0204 RECORDKEEPING

Client case record. An individual case record shall be maintained on each child that contains the following:

(1) written consent for placement;

(2) documentation of placement authority;

(3) completed application for services that includes demographic information on the child and the child's family;

(4) consents for release of information, emergency medical treatment, family time/visitation;

(5) a medical examination report completed within two weeks after admission unless the child's health status indicates the completion of a medical examination report sooner and copies of subsequent medical examination reports;

(6) medical records and immunization records;

(7) intake study and related documents;

(8) out-of-home family services agreement and biweekly reviews;

(9) family contact and visitation plan, including type, duration, location both on-site and off-site and frequency, as well as any rationale for restrictions on family involvement. The facility shall maintain documentation of all family time;

(10) birth certificate or other documentation that verifies the child's birth;

(11) court orders;

(12) documentation of medical insurance;

(13) consents for time-limited, audio-visual recording signed by both the child and parent or guardian , or legal custodian;

(14) progress notes; and

(15) discharge summary including date of discharge, time of discharge and the name, address, telephone number, and relationship of the person or agency to whom the child was discharged, a summary of services provided during care, needs which remain to be met and plans for the services needed to meet these goals.

History Note: *Authority G.S. 131D-10.5; 143B-153;*
Eff. July 1, 1999 (See S. L. 1999, c.237, s. 11.30);
Amended Eff. October 1, 2008;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017.