STATE OF DELAWARE

PLAN OF SAFE CARE (Version 1 – Long)

For Infants with Prenatal Substance Exposure and their Families

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INTRODUCTION: This Plan of Safe Care (POSC) is being developed to ensure that necessary services and supports are in place for the mother, infant and family upon discharge from the birthing hospital. The POSC is developed by gathering information from the mother and her family, from the birthing hospital medical record and social worker notes, as well as input from community partners involved in supporting the mother and infant. The Family Assessment Form may be used as an information gathering tool to assist with the preparation of the POSC. A copy of this POSC will be shared with the identified "Plan Participants" in Section C of this document with the consent of the family within 48 hours after infant is discharged from the hospital.

A. FAMILY INFORMATION

DATE: ____________________

INFANT

Infant's Name (as it appears on birth certificate): ____________________ DOB: __________ Gender: _____

Birth Hospital: ____________________

PARENT(S)

Mother's Full Name: ____________________ DOB: ____________________

Street Address: ____________________ City: ______________ State: _______ Zip: _________

Contact/Cell Number: ____________________

Mother's Employer: ____________________ Employer Contact/Number: ____________________

Father's Full Name: ____________________ DOB: ____________________

Street Address: ____________________ City: ______________ State: _______ Zip: _________

Contact/Cell Number: ____________________

Father's Employer: ____________________ Employer Contact/Number: ____________________

SECONDARY CAREGIVER(S) (If one parent is not involved):

Name DOB Relationship to Parent

____

____

SUPPORT PERSON(S) for Parents and/or Child

Name DOB Relationship to Parent(s) and/or Child

____

____

SIBLING(S) of Child

Name DOB Resides with? (Name/address/City/State/Zip)

____

____

____

____

B. PLAN OF SAFE CARE COORDINATOR (“POSC Coordinator”)

*The primary role of the POSC Coordinator is the preparation, implementation and oversight of the POSC for the family. The POSC Coordinator will be responsible for ensuring appropriate referrals for services are made for the infant and family. The POSC Coordinator will act as the primary point of contact for the family and Plan Participants during the development and implementation period. The POSC Coordinator will share information, with informed consent, with the Plan Participants.

POSC Coordinator’s Name: ____

Phone: ________________________ **Email:** ____

Fax: __________________________

POSC Coordinator’s Supervisor’s Name: ____

Phone: ________________________ **Email:** ____

Fax: __________________________

POSC Coordinator’s Agency Name: ____

C. PLAN PARTICIPANTS for Infant and Family Care

***The Plan Participants are the partners involved in the development and implementation of the POSC. All identified Plan Participants below will receive a copy of this POSC from the POSC Coordinator within 48 hours after the hospital Plan of Safe Care Discharge Meeting.**

1. Birthing Hospital and Social Worker Name: ______________________________

   Phone: ____________________

2. DFS/Child Welfare Worker Name: ______________________________

   Phone: ____________________

3. Infant's Primary Care Doctor Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

4. Infant's Specialist Physician Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

5. Home Visiting Nurse Agency and Provider Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

6. Mother's PCP/OB/GYN Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

7. Mother's SUD or MAT Treatment Provider Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

8. Father's SUD or MAT Treatment Provider Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

9. Mother's Mental Health Treatment Provider Name: ______________________________

   Phone: ____________________ Next Appointment Date: ____________________

10. Father's Mental Health Treatment Provider Name: ______________________________

Phone: ____________________ Next Appointment Date: ______________________________

11. Peer Recovery Coach Name: ______________________________

Phone: ____________________ Next Appointment Date: ______________________________

12. Other: ______________________________

Phone: ____________________ Next Appointment Date: ______________________________

D. IDENTIFIED NEEDS, RISKS AND INTERVENTIONS FOR THE FAMILY

***Based upon the information gathered by the POSC Coordinator during the Family Assessment phase, the following section identifies the needs of the infant, mother, father or other caregiver, and the referrals that are being made for appropriate services and treatment for the family.**

1. INFANT RISKS/NEEDS — REFERRALS MADE BY POSC COORDINATOR AT HOSPITAL DISCHARGE

a) Exposure/Withdrawal Symptoms

Reason for Referral: ______________________________

Referred to: ______________________________

Referral Contact Person and Phone: ______________________________

Date Referred: ______________________________

b) Developmental Needs/Child Development Watch

Reason for Referral: ______________________________

Agency Referred to: ______________________________

Agency Contact Person and Phone: ______________________________

Date Referred: ______________________________

c) Other Medical Conditions

Reason for Referral: ____

Medical Facility Referred to: ____

Medical Contact Person and Phone: ____

Date Referred: ____

Special Medical Equipment needed? If so, type of equipment? ______________________________

Special Medical Equipment training needed? ______________________________________

If so, date training was completed by parents/caregivers: ______________________________

d) Infant Sleeping Arrangements:

Type of sleeping arrangements for infant in the home?

Crib: ______ Pack-n-Play: ______ Bassinet: _______ Other: ______________________

Parents/Caregivers were provided Infant Safe Sleeping education on this date: ______________________

Agency/person(s) who provided Infant Safe Sleeping education to parents/caregivers? ____________________

____

Parents/Caregivers acknowledge understanding of Infant Safe Sleeping education: ______________________

Parents/Caregivers Initials Here: ____

e) Other Infant Needs/Risks

Reason for Referral: ____

Agency/Person Referred to: ____

Contact Person and Phone: ____

Date Referred: ____

2. MOTHER'S NEEDS | **REFERRALS MADE BY POSC COORDINATOR**

a) Substance Use/Abuse

Reason for Referral: ______________________________

Currently Engaged in Treatment? If so, name of Current Provider: ______________________________

If not, Agency Referred to: ______________________________

Agency Contact Person and Phone: ______________________________

Date Referred: ______________________________

b) Alcohol Use/Abuse

Reason for Referral: ______________________________

Currently Engaged in Treatment? If so, name of Current Provider: ______________________________

If not, Agency Referred to: ______________________________

Agency Contact Person and Phone: ______________________________

Date Referred: ______________________________

c) Mental/Behavioral Health

Reason for Referral: ______________________________

Currently Engaged in Treatment? If so, name of Current Provider: ______________________________

If not, Agency Referred to: ______________________________

Agency Contact Person and Phone: ______________________________

Date Referred: ______________________________

d) Parenting Skills/Attachment/Bonding

Reason for Referral: ______________________________

Agency Referred to: ______________________________

Agency Contact Person and Phone: ______________________________

Date Referred: ____

e) Family Planning Needs

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: ____

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

g) Other

Describe: ____

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

3. FATHER'S (or Other Caregiver's) NEEDS   REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse   Reason for Referral: ____________________

Currently Engaged in Treatment? If so, name of Current Provider: ____________________

If not, Agency Referred to: ____________________

Agency Contact Person and Phone: ____________________

Date Referred: ____________________

b) Alcohol Use/Abuse   Reason for Referral: ____________________

Currently Engaged in Treatment? If so, name of Current Provider: ____________________

If not, Agency Referred to: ____________________

Agency Contact Person and Phone: ____________________

Date Referred: ____________________

c) Mental/Behavioral Health   Reason for Referral: ____________________

Currently Engaged in Treatment? If so, name of Current Provider: ____________________

If not, Agency Referred to: ____________________

Agency Contact Person and Phone: ____________________

Date Referred: ____________________

d) Parenting Skills/Attachment/Bonding

Reason for Referral: ____________________

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

e) Family Planning Needs

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

f) Basic Needs Housing/Food/Transportation

Reason for Referral: ____

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

g) Other

Reason for Referral: ____

Agency Referred to: ____

Agency Contact Person and Phone: ____

Date Referred: ____

E. OTHER SUPPORT SERVICES FOR FAMILY

TYPE OF SERVICE	REFERRALS MADE BY POSC COORDINATOR
a) Home Visiting Nursing Program	Date Referred: ______
	Agency Referred to: ______
	Agency Contact Name and Phone: ______
b) WIC	Date Referred: ______
	Agency Referred to: ______
	Agency Contact Name and Phone: ______
c) Employment/Training	Date Referred: ______
	Agency Referred to: ______
	Agency Contact Name and Phone: ______
d) Financial Assistance	Date Referred: ______
	Agency Referred to: ______
	Agency Contact Name and Phone: ______
e) Parenting Class	Date Referred: ______
	Agency Referred to: ______
	Agency Contact Name and Phone: ______

f) Managed Care Organization

Date Referred: ______________________________

Agency Contact Name and Phone: ______________________________

g) Other

Date Referred: ______________________________

Agency Referred to: ______________________________

Agency Contact Name and #:______________________________

_______ Hospital Education Provided to Mother/Father or other Caregivers (check all that apply):

_____ Safe Sleeping
_____ SIDS
_____ Abusive Head Trauma
_____ Infant Feeding
____ Newborn Safety
____ NAS Withdrawal Symptoms and Management
____ Family Planning
____ Other: ______________________________

F. DISCHARGE AND FOLLOW UP

Date of Discharge for Mother: ____________________

Date of Discharge for Infant: ____________________

Infant Discharged to whom (primary caregiver(s): ____________________

Discharge destination (primary caregiver(s) address): ____________________

Secondary/Part-time destination (name of caregiver and address): ____________________

Frequency that infant will reside/visit at Secondary/Part-time address: ____________________

DFS Child Safety Agreement in addition to POSC? ____________________

If yes, provide details: ____________________

____

Explain Frequency of Contact by Plan of Safe Care Coordinator and Plan Participants with the Family (ie.weekly):____________________

____

____

____

Date of Next Multidisciplinary Meeting (in person or via teleconference) with Plan Participants to monitor POSC progress and challenges: ____________________

____

Plan of Safe Care Progress/Challenges/Additional Needs: ____________________

____

Date of Termination of POSC: ____________________

G. CONSENT FOR INFORMATION SHARING

By signing below, Mother, Father or other caregiver(s) acknowledge that the Plan of Safe Care has been prepared, reviewed and thoroughly discussed. It is understood that medical information will be shared/disclosed with the Plan Participants (Section C) under this written consent as provided by HIPPA (45 CFR 160, 164). It is also understood that substance use treatment information will be shared/disclosed with the Plan Participants under this written consent per 42 CFR Part 2. The Mother, Father or other caregiver(s) hereby consent to the sharing of the POSC with the Plan Participants.

The Plan Participants will regularly communicate and share information to ensure that timely referrals for services are made by the POSC Coordinator and that the appropriate services are delivered to the family. The POSC Coordinator and Plan Participants agree to ensure confidentiality of the information received through the POSC and agree to only share information with the identified Plan Participants.

The POSC Coordinator hereby confirms that the Division of Family Services has been notified of the infant's birth, this Plan of Safe Care has been prepared for the infant and family and a copy of the Plan has been provided to the Plan Participants listed in Section C of this document with mother's consent.

Plan of Safe Care Coordinator: ________________________________ Date _______________

Supervisor: ____ Date _______________

Parent Signature: ____ Date _______________

Parent Signature: ____ Date _______________

Other Caregiver: ____ Date _______________

Other Support Person:_______________________________________ Date _______________

Other plan participant: _______________________________________ Date ________________

Other plan participant: ____ Date ________________ (Version: 9/2018)