|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name** (first, last): |  | **DOB**: |  | **Alternate Caregiver Name:** |  |
| **Mother’s Name** (first, last): |  | **DOB**: |  | **Alternate Caregiver Relationship to child**: |  |
| **Father’s (co-parent) Name:** |  | **DOB:** |  | **Alternative Phone:** |  |
| **Primary Zip code**: |  | **Primary Phone**: |  | **Email**: |  |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Family Needs (i.e housing, food, medical care)** | **Family Strengths and Goals** |
|  |  |

**Support Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Support Services | Discussed | Active | Referred | Organization | Contact | Comments |
| \*Women, Infants and Children (WIC) food support |  |  |  |  |  |  |
| TANF (cash assistance) |  |  |  |  |  |  |
| SNAP (food assistance) |  |  |  |  |  |  |
| Transportation assistance |  |  |  |  |  |  |
| Shelter/housing assistance |  |  |  |  |  |  |
| Emergency Food Referral |  |  |  |  |  |  |
| Medical Insurance |  |  |  |  |  |  |

**Adult Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Support Services | Discussed | Active | Referred | Organization | Contact | Comments |
| \*Substance Use Assessment and Treatment |  |  |  |  |  |  |
| Primary Health Care/OBGYN |  |  |  |  |  |  |
| \*Maternal Child Centralized Intake  (Home Visiting) |  |  |  |  |  |  |
| Behavioral Health Treatment |  |  |  |  |  |  |
| Domestic Violence/IPV |  |  |  |  |  |  |
| Smoking Cessation |  |  |  |  |  |  |
| Parenting Classes |  |  |  |  |  |  |
| Immigration Services |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |

**Children Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Support Services | Discussed | Active | Referred | Organization | Contact | Comments |
| \*Early Intervention (all infants exposed to substances are eligible for EI monitoring) |  |  |  |  |  |  |
| \*Safe Sleep Education |  |  |  |  |  |  |
| Pediatric Primary Care |  |  |  |  |  |  |
| Sub-specialty Medical Care (i.ie neurology, cardiology, etc.) |  |  |  |  |  |  |
| Diapers and/or Formula |  |  |  |  |  |  |
| Crib and/or Car seat |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Organization/Relationship to Child** | **Telephone number** | **Email Address** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Attendance**

I acknowledge I have participated in the development of this Plan of Safe Care (POSC), I have a copy of the POSC, I will share the POSC with my child’s primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

**Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_provided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_with the POSC upon discharge.**

**Provider signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**