STATE OF DELAWARE

PLAN OF SAFE CARE

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/Smart Start	
	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	____	Newborn Safety
_____	SIDS	____	NAS Withdrawal Symptoms and Management
_____	Abusive Head Trauma	____	Family Planning
_____	Infant Feeding	____	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: _____

_____

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)