**STATE OF DELAWARE**

**PLAN OF SAFE CARE (Short Version)**

For Infants with Prenatal Substance Exposure and their Families

This Plan of Safe Care is being developed to identify necessary services and supports for the infant, mother, and family upon discharge from the birthing hospital. The goal is to ensure the safety and well-being of the infant while providing the family with ongoing services such as physical and mental health, substance use treatment, parenting education and other family needs.

**Section I: Family Information** **Date of Discharge Meeting:**

|  |  |  |
| --- | --- | --- |
| Infant’s Name: Click here to enter text. | Date of Birth: Click here to enter text. | Gender: Click here to enter text. |
| Birth Hospital: Click here to enter text. | Weight: Click here to enter text. | Discharge Date: Click here to enter text. |

|  |  |
| --- | --- |
| Mother’s Full Name: Click here to enter text. | Date of Birth: Click here to enter text. |
| Street Address: Click here to enter text. | City/State/Zip: Click here to enter text. |
| Cell Number: Click here to enter text. | Employer Name/Number: Click here to enter text.  |

|  |  |
| --- | --- |
| Father’s Full Name: Click here to enter text. | Date of Birth: Click here to enter text. |
| Street Address: Click here to enter text. | City/State/Zip: Click here to enter text. |
| Cell Number: Click here to enter text. | Employer Name/Number: Click here to enter text. |

|  |  |
| --- | --- |
| Other Caregiver(s) Full Name: Click here to enter text. | Date of Birth: Click here to enter text. |
| Relationship to Parent: Click here to enter text. |  |
| Sibling Full Name: Click here to enter text. | DOB: Click here to enter text. | Resides with: Click here to enter text. |
| Sibling Full Name: Click here to enter text. | DOB: Click here to enter text. | Resides with: Click here to enter text. |
| Sibling Full Name: Click here to enter text. | DOB: Click here to enter text. | Resides with: Click here to enter text. |
| Sibling Full Name: Click here to enter text. | DOB: Click here to enter text. | Resides with: Click here to enter text. |

**Section II: Plan of Safe Care Coordinator and Plan Participants:** The role of the POSC Coordinator is to prepare, implement, and monitor the POSC for the family. The POSC Coordinator is responsible for ensuring appropriate referrals are made and services are delivered to the infant and family. The POSC Coordinator is the primary point of contact for the family and Plan Participants. The POSC Coordinator will provide a copy of the POSC to the Plan Participants within 48 hours after the hospital Plan of Safe Care Discharge Meeting.

|  |  |
| --- | --- |
| Plan of Safe Care Coordinator Name: Click here to enter text. | Phone: Click here to enter text. |
| Birthing Hospital Social Worker Name: Click here to enter text. | Phone: Click here to enter text. |
| DFS Worker: Click here to enter text. | Phone: Click here to enter text. |
| Infant’s Primary Care Doctor Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Infant’s Specialist Doctor Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Home Visiting Nurse Agency and Provider Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Mother’s Primary Care Doctor/OB-Gyn Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Mother’s SUD/MAT Provider Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Mother’s Mental Health Provider Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Father’s SUD/MAT Provider Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Father’s Mental Health Provider Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Peer Recovery Coach Name: Click here to enter text. | Phone: Click here to enter text.Appt. Date: Click here to enter text. |
| Other Support Person Name: Click here to enter text. | Phone: Click here to enter text. |

**Section III: Prenatal Substance Exposure**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Substance Exposure:** | **Prescribed** | **Not Prescribed** | **Medication Administered to Infant for Withdrawal? (y/n)** |
| Methadone |[ ] [ ]  Click here to enter text. |
| Buprenorphine (Subutex or Suboxone) |[ ] [ ]  Click here to enter text. |
| Marijuana |[ ] [ ]  Click here to enter text. |
| Opioids (list type)  |[ ] [ ]  Click here to enter text. |
| Benzodiazepine |[ ] [ ]  Click here to enter text. |
| Amphetamines |[ ] [ ]  Click here to enter text. |
| Cocaine |[ ] [ ]  Click here to enter text. |
| Heroin/Fentanyl |[ ] [ ]  Click here to enter text. |
| PCP |[ ] [ ]  Click here to enter text. |
| Alcohol |[ ] [ ]  Click here to enter text. |
| Other:  |[ ] [ ]  Click here to enter text. |

**Section IV: Assessment of Needs and Referrals for Services for the Family**

Based upon the information gathered by the POSC Coordinator during the family assessment phase, the following section identifies the possible needs of the infant, mother, father or other caregiver, and the referrals made for appropriate services and treatment for the family.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Infant Need(s):** | **Service/Provider Referred To:** | **Family Accepted Service (Y/N)** | **Referral Date:** | **30/60 Day Update:** |
| 1. Developmental Screening | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2. Medical Conditions | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3. Home Visiting Nurse | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 4. Other | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mother’s Need(s):** | **Service/Provider Referred To:** | **Family Accepted Service (Y/N)** | **Referral Date:** | **30/60 Day Update:** |
| 1. Substance Use/Abuse (List type of drug(s)):Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 2. Alcohol Use/AbuseClick here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 3. Mental Health (List all diagnoses):Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 4. Parenting Skills Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 5. Housing Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 6. Other | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Father’s Need(s)** | **Service/Provider Referred To:** | **Family Accepted Service (Y/N)** | **Referral Date:** | **30/60 Day Update:** |
| 1. Substance Use/Abuse (List type of drug(s)):Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 2. Alcohol Use/AbuseClick here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 3. Mental Health (List all diagnoses):Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 4. Parenting Skills Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 5. Housing Click here to enter text. | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |
| 6. Other | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** | **Click here to enter text.** |

**Section V: Hospital Education Provided to Mother, Father and Other Caregiver(s)** (check all that apply):

|  |  |  |
| --- | --- | --- |
| Safe Sleeping: [ ]  | SIDS: [ ]  | Abusive Head Trauma: [ ]  |
| Infant Feeding: [ ]  | Newborn Safety: [ ]  | NAS Symptoms/Management: [ ]  |
| Family Planning: [ ]  | Other: Click here to enter text. [ ]  | Other: Click here to enter text. [ ]  |

**Section VI: Infant Safe Sleeping Arrangements** (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| Crib: [ ]  | Pack-n-Play: [ ]  | Bassinet: [ ]  | Other: [ ]  |
| Parents/Caregivers were Provided Infant Safe Sleeping Education on this Date: Click here to enter text. |
| Agency/Person who provided Infant Safe Sleeping Education: Click here to enter text. |
| Parents/Caregivers Initials confirming understanding of Infant Safe Sleeping Education: Click here to enter text. |

**Section VII: Child Safety and Discharge**

|  |  |
| --- | --- |
| Child Safety Agreement in addition to POSC? [ ]  | If yes, provide details: Click here to enter text. |
| Infant Discharged to whom: Click here to enter text. | Date of Discharge: Click here to enter text. |
| Discharge Destination (address): Click here to enter text.  | Secondary Destination (address): Click here to enter text. |

**Section VIII: Monitoring**

|  |  |  |
| --- | --- | --- |
| 30 Day Update: Click here to enter text. | 60 Day Update: Click here to enter text. | 90 Day Update: Click here to enter text. |
| 120 Day Update: Click here to enter text. | Date of Closure/Termination: Click here to enter text. | Closure Notes: Click here to enter text. |

**Section IX: Consent for Information Sharing and Signatures**

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

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 will ensure confidentiality of the information received through the POSC.

The POSC Coordinator hereby confirms that the Division of Family Services has been notified of the infant’s birth, this POSC has been prepared for the infant and family and a copy of the POSC will be provided to the Plan Participants within 48 hours after this date.

|  |  |
| --- | --- |
| POSC Coordinator:  | Date: |
| POSC Coordinator’s Supervisor:  | Date: |
| Mother: | Date: |
| Father: | Date: |
| Other Caregiver: | Date: |
| Other: | Date: |