|  |  |  |  |
| --- | --- | --- | --- |
| SEAL31.TIF | **PLAN OF SAFE CARE**  State Form 56565 (R3 / 9-23)  DEPARTMENT OF CHILD SERVICES |  | Date plan was created *(month, day, year)* |
|  |  |

*INSTRUCTIONS:*

1. *Collaborate with the family and professional partners and agencies involved in caring for the family to develop a Plan of Safe Care for each infant, under the age of one (1) year, who is identified as born affected by or exposed to substance use. The Plan of Safe Care should be completed regardless of the decision to substantiate or unsubstantiate. See policies 4.22 Making an Assessment Finding and 4.42 Plan of Safe Care for additional information;*

***Note:*** *A separate Safety Plan must be developed when:*

* 1. *A plan is needed to ensure safety prior to, or in addition to, the development of a Plan of Safe Care,*
  2. *Siblings have differing safety needs.*

1. *Ask the parents and each included adult individual to sign the Plan of Safe Care and provide each with a copy;*

***Note:*** *If one parent refuses or is unable to sign the POSC, information on that parent may not be shared with others and a separate POSC should be completed for that parent/caregiver.*

1. *Provide a copy of the Plan of Safe Care to each included adult individual, professional, or agency included in the plan and authorized by the parents;*
2. *Provide a copy of the Plan of Safe Care to the court, if there is court involvement; and*
3. *Upload the completed Plan of Safe Care to the case management system and review the plan regularly throughout DCS involvement until the child turns one (1) year of age. Develop a new Plan of Safe Care and/or Safety Plan with the family when changes in safety, risk, or protective factors warrant a revision. See policies 4.19 Safety Planning, 4.41 Safety Staffing, and 5.21 Safety Planning for additional information.*

|  |  |
| --- | --- |
| Assessment / case name | Assessment / case identification number |
| Name of Family Case Manager (FCM) | Telephone number of FCM  (     ) |
| Name of infant | Date of birth *(month, day, year)* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HOUSEHOLD MEMBERS** | | | | | |
| **Name** | **Age** | **Relationship to Infant** | **Name** | **Age** | **Relationship to Infant** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **OTHER PLAN PARTICIPANTS AUTHORIZED BY PARENTS**  **(e.g., Pediatrician, OB/GYN, Mental Health and Substance Use Treatment Providers, Community Services, and other infant or family supports)** | | |
| **Name** | **Agency / Relationship to Infant** | **Contact Information** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **PROTECTIVE FACTORS** |
| *Possible protective factors may be nurturing and attachment to the child, knowledge of parenting and of child and youth development, parental resilience, social connections, concrete supports, and social and emotional competence of the child.* |
|  |

|  |
| --- |
| **RISKS AND NEEDS** |
| Risks and needs of infant |
| Risks and needs of Parent 1 |
| Risks and needs of Parent 2 |
| Risks and needs of other household members and caregivers |

|  |  |  |
| --- | --- | --- |
| **NEEDS OF INFANT** | **PLANS *(Include what, when, and where.)*** | **WHO *(Individuals / Agencies)*** |
| Infant Medical Care  (Immediate, ongoing, and emergency) |  |  |
| Medical Coverage |  |  |
| Safe Sleep |  |  |
| Developmental Screening and Intervention(s) |  |  |
| Other Supports |  |  |
| **NEEDS OF PARENT 1** | **PLANS *(Include what, when, and where.)*** | **WHO *(Individuals / Agencies)*** |
| Substance Use Disorder Assessment / Treatment (Including Medication Assisted Treatment) |  |  |
| Medical Care  (e.g. post-partum, pain management, etc.) |  |  |
| Mental Health Assessment / Treatment |  |  |
| Parenting Support |  |  |
| Other Supports |  |  |
| **NEEDS OF PARENT 2** | **PLANS *(Include what, when, and where.)*** | **WHO *(Individuals / Agencies)*** |
| Substance Use Disorder Assessment / Treatment (Including Medication Assisted Treatment) |  |  |
| Mental Health Assessment / Treatment |  |  |
| Parenting Support |  |  |
| Other Supports |  |  |

|  |  |  |
| --- | --- | --- |
| **NEEDS OF FAMILY / CAREGIVER** | **PLANS *(Include what, when, and where.)*** | **WHO *(Individuals / Agencies)*** |
| Safe Housing |  |  |
| Food |  |  |
| Transportation |  |  |
| Appropriate Child Care |  |  |
| Referrals to Community Resources  (e.g., WIC, home visiting program, etc.) |  |  |
| Additional Service Referrals |  |  |
| Other |  |  |
| Crisis Planning |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SIGNATURES** | | | | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of Parent 1 | | | Date *(month, day, year)* | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of Parent 2 | | | Date *(month, day, year)* | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of other adult participant *(Specify role.)* | | | Date *(month, day, year)* | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of other adult participant *(Specify role.)* | | | Date *(month, day, year)* | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of other adult participant *(Specify role.)* | | | Date *(month, day, year)* | |
| I understand that this Plan of Safe Care will be shared with the individuals and service providers identified above for purposes of treatment, and that DCS may monitor this plan as required by law. | | | | |
| Signature of other adult participant *(Specify role.)* | | | Date *(month, day, year)* | |
| Signature of Family Case Manager (FCM) | Date *(month, day, year)* | Signature of reviewing FCM supervisor | | Date *(month, day, year)* |
| Printed name of FCM | Contact number  (     ) | Printed name of reviewing FCM supervisor | | Contact number  (     ) |
| **Ongoing Plan of Safe Care Review *(If a review of this Plan results in modifications, a new Plan of Safe Care and/or Safety Plan should be completed.)*** | | | | |
| Signature of Family Case Manager | Date *(month, day, year)* | Signature of reviewing supervisor | | Date *(month, day, year)* |
| Signature of Family Case Manager | Date *(month, day, year)* | Signature of reviewing supervisor | | Date *(month, day, year)* |
| Signature of Family Case Manager | Date *(month, day, year)* | Signature of reviewing supervisor | | Date *(month, day, year)* |
| Signature of Family Case Manager | Date *(month, day, year)* | Signature of reviewing supervisor | | Date *(month, day, year)* |