

Integrated Team Plan of Safe Care Staffing

Plan of Safe Care

Date _____ Name of Mother _____

Name of Infant _____ Date of Birth _____

a. Mother's Substance Use and Mental Health Needs (please include all available information including mother's self-report)

(1) Substance Use History _____

(2) Mental Health History _____

(3) Treatment History _____

(4) Medication Assisted Treatment History _____

(5) Referrals for Services _____

(6) Plan for Mother _____

b. Infant's Medical Care

(1) Prenatal Exposure History _____

(2) Hospital Care (NICU), length of stay, diagnosis _____

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(3) Other Medical or Developmental Concerns _____

(4) Pediatric Care and Follow Up _____

(5) Referral to Early Intervention and other services _____

c. Mothers Medical Care _____

(1) Prenatal Care History _____

(2) Pregnancy History _____

(3) Other Medical Concerns _____

(4) Screening and Education _____

(5) Follow up Care with OB/GYN _____

d. Family/Caregiver History and Needs _____

1) Prior involvement with child welfare _____

2) Child safety or risk concerns _____

3) Parent-child relationship _____

4) Family history _____

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- 5) Living Arrangements _____

- 6) Current support network _____

- 7) Current services _____

- 8) Needed supports/services _____

Case Manager/Responsible Representative for Follow Up _____
Agency _____ Phone Number _____
Recommendation _____
Additional Staffing Needs _____ Follow-Up Date _____
Admission to NICU Date _____ Estimated Discharge Date _____

Identified Goals:

Mother/Caregiver Name (Please Print) _____

Mother/Caregiver Signature : _____ Date: _____

Mother/Caregiver Contact Information: _____

Other Notes:

