**Plan of Safe Care**

Licking County

**Date of Plan:**

**Pregnant/Parenting Individual’s Name:**       **DOB:**

**Infant’s Delivery Date:**

|  |  |
| --- | --- |
| **Child Name** | **Age** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

**Primary Caregiver Name & Age (if different than Pregnant/Parenting Individual):**

**Secondary Caregiver Name & Age:**

|  |
| --- |
| **Managed Care Plan** |
| Buckeye:      |
| CareSource:      |
| Molina:      |
| Paramount:      |
| United:      |
| Private/Name of Provider:      |

**Pregnant/Parenting Individual/Caregiver’s Contact Information:**

**Address:**

**Telephone:**

**Text:**

**Email:**

**Brief description of the impact of substance use on the family:**

**Agency Involvement (complete all that apply):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name** | **Role** | **Phone Number** | **Helpful?** |
| **Children Services** |       |       |       | [ ] **Y**[ ] **N** |
| **Court Program** |       |       |       | [ ] **Y**[ ] **N** |
| **Physician** |       |  |       | [ ] **Y**[ ] **N** |
| **Psychiatric Agency** |       |       |       | [ ] **Y**[ ] **N** |
| **Psychological Assessment** |       |       |       | [ ] **Y**[ ] **N** |
| **Therapist** |       |       |       | [ ] **Y**[ ] **N** |
| **Other:**       |       |       |       | [ ] **Y**[ ] **N** |
| **Other:**       |       |       |       | [ ] **Y**[ ] **N** |

**Needs of Infant:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Past Engagement** | **Currently Engaged**  | **Needs Referral?** | **Who is providing service?**. | **Date of last appointment**  | **Confirmed?** |
| **Primary Physician**  | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Specialist** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Early Intervention Specialist** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Discussed with Caregiver** | **Yes** | **No** | **Comments**: |
| Safe Sleep |[ ] [ ]        |
| Early Care |[ ] [ ]        |
| Nutrition |[ ] [ ]        |

**Needs of other children in the home:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Past Engagement** | **Currently Engaged** | **Needs Referral?** | **Who is providing service?** | **Date of last appointment** | **Confirmed** |
| **Primary Physician** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Specialist** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Early Intervention Specialist** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |

**Needs of the Pregnant/Parenting Individual:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Currently Engaged** | **Needs Referral?** | **Who is providing service?** | **Date of last appointment** | **Confirmed** |
| **Medical** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Mental Health** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **SUD** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Medication Management** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Mother-child Bonding** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Breastfeeding** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Parenting Suport** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Family Support** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Case Management** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Childcare** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Benefits Eligibility Determination**  | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Housing** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Employment** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Transportation**  | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Support Network** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Recovery Support** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Domestic Violence Support** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Family Planning (contraception)** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |

**Needs of Secondary Caregiver:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Currently Engaged** | **Needs Referral?** | **Who is providing services?** | **Date of last appointment**  | **Confirmed** |
| **Medical** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Mental Health** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **SUD** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Medication Management** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Parenting Skills** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Benefits Eligibility Determination** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Employment** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Housing** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |
| **Transportation** | [ ] **Y**[ ] **N** | [ ] **Y**[ ] **N** |       |       | [ ] **Y**[ ] **N** |

**Follow-up Roles and Responsibilities:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Provider** | **Date** | **Notes** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Plan of Safe Care Coordination Participant Signatures:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signatures of Pregnant/Parenting Individual/Caregiver(s):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**