Los Angeles County
Plan of Safe Care

The goal of a Plan of Safe Care is to address the health and substance use disorder treatment needs of the infant and affected parent or caregiver. The plan is to be developed alongside the parent with input from the other caregiver, as well as any collaborating professional partners and agencies involved in caring for the infant and family.

DATE:	**HOSPITAL NAME:**
PARENT'S NAME:	**CWS/CMS REFERRAL/CASE # *(when applicable)*:**
PREFERRED NAME:	**PREFERRED LANGUAGE:**
ADDRESS:	**TELEPHONE:**
INFANT'S NAME:	**INFANT'S DOB/ANTICIPATED DELIVERY DATE:**

Family Strengths and Supports

Resiliency: Parenting can be stressful, but parents' ability to manage and bounce back from challenges is what creates for strong resiliency. *What helps you cope with everyday life? Where do you draw your strength?*

Social Connections: Families need help in raising and keeping children safe. *Who is there to help/support you and the child? What is their relation to you?*

Concrete Supports: Access to resources that help meet the basic needs of your family can help you focus more on being a parent. *Are there any local services that have been or might be able to support you? (i.e., diapers/wipes, baby clothes, car seat, formula if not breastfeeding, etc.)*

Knowledge of Parenting & Child Development: It's important for caregivers to know and understand child development so that the caregivers can adjust their parenting and expectations based on the child's needs and developmental path (or trajectory). *Where, or from whom, will you gain information about child development in general and specifically about your own child?*

Nurturing/Attachment: Building a close bond helps parents better understand, respond to, and communicate with their children. *What are ways you will connect with your child to nurture the feelings of love and support?*

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Identify all services the family is currently engaged in and new referrals to meet infant/parent/family's need:

Resource/Service	Currently Engaged	Referral/ Enrollment Date	Discussed	Declined	Organization
Outpatient Substance Use Care/MAT	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Mental Health Counseling	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Residential Treatment	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Safe Sleep Plan	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Child Care	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Home visiting	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Parenting Class	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Family Resource Center	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
WIC	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Financial Assistance	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Housing Assistance	◯	Referred: Enrolled:	◯	◯	Name: Phone #:
Other:	◯	Referred: Enrolled:	◯	◯	Name: Phone #:

Achieving Goals

Utilizing Identified Strengths: After reflecting on your current strengths, it's important to identify how you plan to utilize them to support you and your family's safety, health and well-being. *How will you build off of your current strengths to support your goals in these areas?*

Pregnant/parenting people who are unsure about treatment should not fear they will be reported for illegal drug use if their baby has withdrawal symptoms from the methadone they were/are prescribed.

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Infant's Health Support

Check all substances exposed prenatally:

- ☐ Alcohol
- ☐ Amphetamine
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Cocaine
- ☐ E-Cigarettes
- ☐ Marijuana
- ☐ Methadone
- ☐ Methamphetamine
- ☐ Opioids
- ☐ Suboxone
- ☐ Other:

Are any of the checked substances prescribed?: ◯ Yes ◯ No

If yes, list the substance(s) prescribed:

At what point(s) during the pregnancy were the checked substance(s) used? What was the frequency?:

History of substance use (including alcohol) prior to pregnancy:

Withdrawal Symptoms of Infant

Positive Toxicology Screening: ◯ Yes ◯ No

If yes, list substance(s):

Experiencing withdrawal symptoms: ◯ Yes ◯ No

Check applicable symptoms below:

- ☐ High pitched cry
- ☐ Sleep disturbance
- ☐ Tremors
- ☐ Respiratory issues
- ☐ Poor feeding
- ☐ Vomiting
- ☐ Loose stools
- ☐ Increased muscle tone

If the infant was prenatally exposed to alcohol, has a screening for Fetal Alcohol Syndrome Disorder (FASD) been conducted?:

◯ Yes ◯ No *If no, when will it need to scheduled?*:

FASD Screening Result: ◯ Yes ◯ No ◯ Unk

Diagnosis of Prenatal Alcohol Exposure (PAE) entered into newborn chart?: ◯ Yes ◯ No

☐ Medication(s) for withdrawal symptoms:

☐ Medical insurance:

☐ Developmental Needs:

☐ Other Medical Conditions:

☐ Comments:

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Please check if any of the following are applicable:

- ☐ Plan of Safe Care was completed and provided to client for continued support and implementation
- ☐ Parent was engaged in services prior to delivery
- ☐ Additional referrals were made for services for the infant and/or birthing parent/caregivers

By signing below, I agree with the Plan of Safe Care developed

Parent/Caregiver Print Name	Parent/Caregiver Signature	Date
Parent/Caregiver Print Name	Parent/Caregiver Signature	Date
Provider/Social Worker Print Name	Provider/Social Worker Signature	Date
Provider/Social Worker Phone Number	Provider/Social Worker Office	