Colorado Comprehensive Plan of Safe Care

A Plan of Safe Care is a helpful tool for families with infants who are affected by substance use during pregnancy. This is your plan and can be used to highlight your family's strengths and connect you to support for keeping you and your baby healthy and safe. It can also change as your needs change. Complete this comprehensive plan with a trusted provider and make sure you get the support you need during pregnancy and after your baby is born. If you have already started a plan (either for yourself, your baby, or both) you can update that one without starting over, or use that plan to guide the creation of this one. Your plan will not be shared, unless you choose to share it. You can choose to share this plan with doctors, service providers, case managers, or others who support you and your baby. Sharing your plan helps make sure the people working with you are also working together, and know about the support you've built.

To promote the best outcomes, a POSC should include information about the (1) infant's health and well-being (2) physical health of impacted caregiver and family (3) behavioral health of impacted caregiver and family (4) parent/caregiver education (5) discharge planning/ consultation (6) referrals and plans for follow-up care. Please be sure to indicate any services that were recommended but ineffective or declined.

Plan of Safe Care for:

Name of Infant: _____ Due Date/Date of Birth:_____ County: _____

Name of Birth Parent: _____ DOB:_____ Preferred Language:_____

Phone number: _____ Can we leave a message at this number? ☐Yes ☐No Email: _____

Name of Other Caregiver: _____ DOB:_____ Preferred Language:_____

Is this person able and willing to provide safe and sober care to you and your child/children? ☐Yes ☐No

Who else is able and willing to provide safe and sober care to you and your child/children? Please list names and phone numbers:

Do you have any complex communication needs?(intellectual disability, traumatic brain injury, hearing/vision/speech impairment:

_____

Date POSC Initiated: _____ Date of last Update: _____ POSC Support Monitor: _____

Birth Event Information

Birth Hospital: _____County: _____ Admission Date:_____

Anticipated Birth Parent Discharge Date:_____ Anticipated Infant Discharge Date: _____

OBGYN/CNM/FM (name and contact info): _____

Infant Primary Care Provider (name and contact info): _____

Labor Support Person(s): _____ Transportation Needed?_____

Emergency Contact?

Name:_____ Phone Number: _____

Address:_____

Household Members (Who else is living with you?)

Name	Age	Relationship to Infant/Parent	Can help provide safe & sober care?	OK to contact in an emergency?	Contact info
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	

Main Supports (Who's in your inner circle - partner, friend, family, doula, support person etc.)
Please consider signing releases so your main support people can communicate with others on your team

Name	Age	Relationship to Infant/Parent	Can help provide safe & sober care?	OK to contact in an emergency?	Contact info
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	
			☐Yes ☐No	☐Yes ☐No	

Family priorities and goals (housing, smoking cessation, parenting support, recovery, etc.)

1.

2.

Any important cultural practices?:

Family strengths: What do you feel like you and your family do well? What makes you happy? What brings a sense of well-being?

1.

2.

3.

Family's Identified Needs

These are things we would like support with

Potential Stressors	Past or current?	Resources Requested?	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Housing instability	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Food insecurity	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Job insecurity	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Transportation challenges	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Access to phone/internet	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Difficulty paying bills	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Disability	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Incarceration	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Parole/probation	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Involvement with child welfare	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Mental health needs	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No

Potential Stressors	Past or current?	Resources Requested?	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Intimate partner/ domestic violence	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Health insurance needs	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Dental care needs	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Mental health needs	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Communication Barriers	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
Other:	☐Past ☐Current ☐ N/A	☐Yes ☐No			☐Yes ☐No
NOTES:					

PLAN FOR BIRTHING PERSON'S HEALTH & WELLBEING	
Priorities for myself (medical, physical, mental/behavioral health, personal needs): 1. 2. 3.	
My Reuse Prevention Support Plan	
Triggers (people, places, things that trigger us)	
Thoughts, feelings, & behaviors that contribute to urges/cravings	
My healthy coping skills & strengths	
My support system (friends, family, peers, programs, etc)	

Resource & Referral Inventory

For assistance finding community support services and resources, please visit: https://www.toughasamother.org/search/

	Status of services	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Medical & Healthcare				
Prenatal Care	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

	Status of services	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Postpartum Care	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Family Planning	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Lactation/Feeding Support	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Other	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Parenting Supports				
Postpartum Supports	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Public Health Nursing Program	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Parenting Groups	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Home Visiting Program	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

	Status of services	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Fussy Baby Network (1-877-6-CRY-CARE)	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Other	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Basic Needs and Social Supports				
Resources for Intimate Partner Violence/ Domestic Violence	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Financial Assistance/TANF	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
WIC/SNAP/Food Assistance	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Housing Assistance	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Family Resource Centers	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Office of Respondent Parents' Counsel	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

Mental Health, Behavioral Health, and Substance Use Treatment Needs For assistance finding licensed treatment providers visit: https://ownpath.co/ or https://www.toughasamother.org/search/ The Maternal Mental Health Hotline is free, confidential, and available 24/7: text or talk 1-833-TLC-MAMA				
	Status of services	**Organization & Contact Info**	**Date of Referral & Warm Handoff**	**POSC Shared?**
Special Connections Programs	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Residential Treatment	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Intensive Outpatient Program (IOP)	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Outpatient Treatment	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Peer Recovery Support	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Harm Reduction Programming	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Medication for Opioid Use Disorder	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Mental/Behavioral Health Counseling	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

	Status of services	Organization & Contact Info	Date of Referral & Warm Handoff	POSC Shared?
Support Groups (NA, AA, Circle of Parents in Recovery etc)	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Smoking Cessation	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Other	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Other	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
NOTES AND OTHER CONSIDERATIONS:				

Caregiver Education

Families are entitled to and should receive this education from their provider prenatally or during the birth hospitalization

Hospital Policies and Practice

Discussed & Education Provided	Yes	No	Date	Notes
Birth hospitalization expectations (NOWS/NAS Care)	☐	☐		
Nursery v. NICU management	☐	☐		
Chest/breastfeeding policies	☐	☐		
Toxicology testing policies	☐	☐		
Mandatory reporting policies	☐	☐		

Preparing for Taking Baby Home

It's helpful to provide this education to all people involved in the care of the infant (i.e. birthparents, family, foster care etc.)

Discussed & Education Provided	Yes	No	Date	Notes
Safe caregiving/child care plan	☐	☐		Who can provide safe & sober child care if you need to go to work or an appoinment or get sick?
Safe sleep	☐	☐		Safe infant sleep means placing your baby in a crib with a firm mattress with no soft bedding or toys. Where will your baby sleep?
Safe storage of substances	☐	☐		Where are medications, alcohol, naloxone, and other substances kept?
Naloxone & accidental ingestion	☐	☐		
Non-pharmacologic care for NAS/NOWS	☐	☐		
Chest/breastfeeding and substance use	☐	☐		
Other	☐	☐		

INFANT DISCHARGE PLAN

(To be completed after the birth event with the parent/caregiver and provider team)

Was the State IEPS Notification Portal Completed? ☐ Yes ☐ No **Date of Notification:** _____ **Completed by:**_____

Identified infant needs (include any medical diagnoses, prescribed medications, known allergies, etc):

Insurance Info:

Discharged to (include name, contact info, and relationship to child):

Follow-up Provider	Clinic/PCP Name: _____ Phone Number:_____ Location:_____ Next visit: _____ ☐Warm handoff completed
Discharge Medications	☐ Rx:_____ ☐Rx: _____ ☐ Naloxone (Narcan) provided at discharge
Feeding Plan	☐ Exclusively nursing ☐ Exclusively bottle feeding ☐ Breastmilk ☐ Formula_____kcal/oz ☐ _____ ounces every _____ hours ☐Nursing and bottlefeeding ☐ Breastmilk ☐ Formula_____kcal/oz ☐ _____ ounces every _____ hours ☐ Other: _____

Notes (include any necessary medical care plan info):

Infant development & learning supports	Complete referral to Early Intervention Services: Online referral form Email: GetStartedwithEI@state.co.us Call: 833-733-3734 (833-REFER-EI)	Info on infant development and services from Early Intervention Colorado: Materials for families and community partners **Consent Form:** English Form Spanish Form **Date of Referral:** _____

Infant Support and Services For assistance finding home visiting programs, visit: https://cohomevisiting.org/find-home-visiting-programs/				
	Status of services	**Organization & Contact Info**	**Date of Warm Handoff**	**POSC Shared?**
Pediatric care/medical home	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Infant mental health provider	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Medical insurance	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Child development specialist	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Child care assistance	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Public health nursing services	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Home visiting programs	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Speciality care provider(s)	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

	Status of services	Organization & Contact Info	Date of Warm Handoff	POSC Shared?
Other:	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No
Other:	☐Currently receiving ☐New referral ☐Discussed ☐Not applicable			☐Yes ☐No

PLAN FOR INFANT BASIC NEEDS AND SUPPLIES		
	Resources Needed?	Plan to support identified needs
Diapers	☐Yes ☐No	
Car Seat	☐Yes ☐No	
Formula	☐Yes ☐No	
Clothing	☐Yes ☐No	
Crib/bassinet/safe sleep space	☐Yes ☐No	
Bottles	☐Yes ☐No	
Other:	☐Yes ☐No	
NOTES:		

Who's a Part of Your Team? (optional)

Date:_____

In the chart below, make a list of people who are helping you or who know something about your life. These can be professionals, or family or friends. It is helpful to sign releases of information for the Department of Human Services (DHS) to be able to talk to these people if they are helping you with your treatment and recovery from substance use. If there is a type of provider on the list below that you would like to start working with, ask for help connecting with that sort of provider. Fill out only the parts that apply to you. Feel free to leave spaces blank if they don't apply.

Role on team: (Type of provider support)	Agency or relationship	Name	Phone Number	OK to text?	Email	How can this person support your plan?
Example: Peer Support	Recovery Coach	Jane Doe	444-444-4444	Y	example@google.com	
Prenatal Care Provider/ OBGYN						
Counselor/Therapist						
Social Worker						
Addiction Medicine Provider						
Child's Pediatrician						

Well Child Appointment Tracker (optional)

Well Child Visits are meetings with your child's pediatrician. The doctor will make sure your child is healthy and growing. They will also talk with you about nutrition and immunizations. It is important to make all of your child's medical appointments, because your baby is growing fast and it's important to make sure they're on a healthy track. Your baby may also need to see other providers to ensure they’re healthy and happy.

Type of Visit	Date and Time	Provider Name and Contact Info	Notes

CHILD WELFARE

Only necessary in situations with or requiring child welfare involvement.

NOTE: A Plan of Safe Care is separate from traditional Safety or Support Plans which are completed during the assessment phase of a case. Caseworkers may reference a Plan of Safe Care when they're documenting parts of the Safety or Support Plan. There may be circumstances in which all three plans are implemented during the course of the assessment.

Is Child Welfare already involved with the family at the time of birth: ☐ Yes ☐ No

If "yes" Caseworker Name and Contact Info: _____

Attorney Name and Contact Info: _____

Was a report to Child Welfare made for this birthing event: ☐ Yes ☐ No **If "yes" have you informed the caregiver?** ☐ Yes ☐ No

Referring Person: _____ **Date of Referral:** _____ **Referral Number:**_____

If making a report to child welfare please be prepared to provide answers the following screening questions during hotline calls or assessments with a caseworker:

Q1: Was the infant born substance exposed? If "Yes" how was this confirmed?

- □ Disclosure by Parent
- □ Positive Drug Test – parent
- □ Positive Drug Test – child*
- □ Other_____
- □ Select all

***If "Positive Drug Test- Child" select Drug Screen Type**

- □ Select all
- □ Blood
- □ Meconium
- □ Umbilical cord (cord/blood)
- □ Urine
- □ Other

Q2: Was a plan of safe care or safe discharge plan created? (if "yes" please ask caregiver for consent to share the plan with child welfare)

Q3: Is the infant experiencing withdrawal symptoms? If "yes" describe support plan specific to the symptoms of withdrawal

Q4: Was the infant born with physical impairments associated with substance exposure?

Q5: Were resources, referrals, or services offered for the infant and caregiver to address their health and substance use treatment needs?

CHILD WELFARE

Only necessary in situations with or requiring child welfare involvement.

Q6: Can the infant eat more than 1oz during a single feeding, sleep at least an hour at a time, or be consoled within 10 minutes of crying?

Q7: Do parents/caregiver display competency in the care taking of the infant?

Q8: Can parent/caregiver assume full responsibility for the infant's care?

Q9: Have 2 caregivers been identified to help support the care taking of the infant? If “yes”- identify caregivers. If “no” - describe the caregivers support plan.

Family Engagement Meetings or Care Conference/Discharge Planning Meetings

Meeting 1: Date: _____ Time:_____ Location_____ Caseworker Name: _____
Caseworker Contact Info: (Phone) _____ (email): _____
Notes:

Meeting 2: Date: _____ Time:_____ Location_____ Caseworker Name: _____
Caseworker Contact Info: (Phone) _____ (email): _____
Notes:

Discharged to: ☐ Biologic/birth parent(s) ☐ Kinship ☐ Foster placement ☐ Other _____

If discharged to a kinship or foster placement did they receive a copy of the infant discharge plan (pg.11-13)
☐ Yes ☐ No ☐ NA

If discharged to a kinship or foster placement have parents signed informed consents for infants to receive services and/or medical care?
☐ Yes ☐ No ☐ NA

If the infant was not discharged with birth parents what are current plans for communication and visitation between birth parent(s) and infant?

NOTES