|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Plan of Safe Care** | | | CASE NAME | | CASE ID |
| DATE COMPLETED | | |
| CASEWORKER’S NAME | | | | | CASEWORKER’S TELEPHONE NUMBER | | |
| CHILD’S NAME | | | | | DATE OF BIRTH | | |
| **Participant Signatures** | | | | | | | |
|  | | |  | | | | |
|  | | |  | | | | |
| A Plan of Safe Care is required for all screened-in intakes that identify a newborn as affected by substances(s), and for all newborns born to a dependent youth to include youth in Extended Foster Care. A Plan of Safe Care is recommended for screened-in intakes that identify a new born as substance exposed. | | | | | | | |
| ESIT Referral was made below | | | | | | | |
| **All newborns experiencing prenatal substance exposure are automatically eligible for ESIT services.** | | | | | | | |
|  | **Plan** | | | **Person / Organization** | | **Contact Information** | |
| **Medical Care for Newborn** |  | | |  | |  | |
| **Safe Housing** |  | | |  | |  | |
| **Safe Sleep** |  | | |  | |  | |
| **Routine Child Care** |  | | |  | |  | |
| **Emergency Child Care** |  | | |  | |  | |
| **Parenting Support** |  | | |  | |  | |
| **Plan for inconsolable crying (i.e., PURPLE crying)** |  | | |  | |  | |
| **Service Referrals**  **(SUD/MH/DV)** |  | | |  | |  | |
| **Referrals to Resources – for example, ESIT, First Steps, Parent Child Assistance Program, Public Health Nurse, Help Me Grow, etc.** |  | | |  | |  | |