Indiana Plan of Safe Care

Plan Type: **Date**

☐ Prenatal ☐ Postnatal (infant-focused) ☐ Postpartum (caregiver-focused)

Prenatal Care Provider **Pediatric Care Provider:**

Patient First Name **Patient Last Name** **DOB**

Email Address **Current Address**

City **State** **Zip Code** **County**

Infant name **Infant Sex** **Due/Birth Date**

PoSC Coordinator

Household Members

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

Needs, Risks, Interventions

Adult/Caregiver Needs	Date Need Identified	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person Providing the Service
Ex: Substance Use Treatment	*6/9/21*	*Yes*	Service already established	*ABC Behavioral Health/Dr. John Doe*
Substance Use Treatment *(includes MAT)*			Choose an item.	
Mental Health Treatment			Choose an item.	
Medical/Physical Health			Choose an item.	
Family Planning *(contraceptive methods and planning)*			Choose an item.	
Smoking Cessation			Choose an item.	
Peer Recovery Support (*certified peers, community-based groups, etc.)*			Choose an item.	

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Adult/Caregiver Needs	Date Need Identified	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person Providing the Service
Parenting Skills & Education			Choose an item.	
Home visiting *(e.g., Healthy Families, My Healthy Baby, Nurse-Family Partnerships, etc.)*			Choose an item.	
Healthcare (*medical, dental coverage*)			Choose an item.	
Financial Assistance			Choose an item.	
Food Assistance			Choose an item.	
Infant Feeding/WIC			Choose an item.	
Housing Assistance			Choose an item.	
Childcare			Choose an item.	
Employment/Training			Choose an item.	
Transportation Needs			Choose an item.	
Other			Choose an item.	
Other			Choose an item.	

Infant Needs	Date Need identified	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person providing the service
Exposure/Withdrawal Needs and Intervention			Choose an item.	
Developmental Screenings and Interventions			Choose an item.	
Other Medical/Physical Health Needs			Choose an item.	
Infant Feeding/WIC			Choose an item.	
Safe Sleep Practices			Choose an item.	
Healthcare Coverage			Choose an item.	
Childcare			Choose an item.	
Basic Needs (i.e., diapers, crib, car seat)			Choose an item.	

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Infant Needs	Date Need identified	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person providing the service
Other			Choose an item.	
Other			Choose an item.	

**Complete if Postnatal Plan Type is selected*

Family Supports, Strengths, and Resources

Plan of Safe Care Participant Signatures		
I understand that this Plan of Safe Care will be shared with the Organization(s) and Contact Person(s) listed above for the purposes of treatment and service collaboration. I understand that information shared is limited to the contents of this form and separate Release(s) of Information should be pursued if additional information is needed.		
Patient:	Signature:	Date:
I understand that this Plan of Safe Care will be shared with the Organization(s) and Contact Person(s) listed above for the purposes of treatment and service collaboration. I understand that information shared is limited to the contents of this form and separate Release(s) of Information should be pursued if additional information is needed.		
PoSC Coordinator:	Signature:	Date:
I understand that this Plan of Safe Care will be shared with the Organization(s) and Contact Person(s) listed above for the purposes of treatment and service collaboration. I understand that information shared is limited to the contents of this form and separate Release(s) of Information should be pursued if additional information is needed.		
PoSC Participant (*Specify role*):	Signature:	Date:
I understand that this Plan of Safe Care will be shared with the Organization(s) and Contact Person(s) listed above for the purposes of treatment and service collaboration. I understand that information shared is limited to the contents of this form and separate Release(s) of Information should be pursued if additional information is needed.		
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