Date: _ _ / _ _ / _ _ _ _

Family Support Plan
(Plan of Safe Care)

Pregnancy and parenting a young child are exciting and challenging times for all parents. Planning and preparation is important – especially for parents who are working on early recovery from substance use. All families deserve help and support: there is no penalty for reaching out or asking for help.

* * Please keep in mind: this is a general document that can be used for families in many different situations before or after the birth of a child; fill out the parts that apply to you and your family. * *

How to use this plan:

Parents and Families: If you are pregnant or recently had a child, this plan can help you find the supports and services you need to keep yourself and your child healthy and safe.You can update this plan over time to keep track of all the work you've done to prepare for parenting, and to show the progress that you've made.

Work on this plan with a provider that you trust (a counselor, case manager, or recovery coach). It's important not to do this work alone. If you don't have someone that you're already working with, ask the staff at the clinic where you received prenatal care, or at a local substance use treatment program. They can connect you with a provider.

Providers: This plan is a guide to assist your work with perinatal women and families. The list of services on page 4 serves as a reminder of available resources that may be useful to your clients. Feel free to edit this plan, to include additional resources that are available in your area. This plan should be completed jointly, with you and your client, in the context of a nonjudgmental conversation.

Ideally, this plan is incorporated into ongoing engagement or care navigation work, rather than completed during a single session. Families may find it helpful to meet monthly with their plan coordinator, for a period of at least 12 months, and update this plan as their circumstances evolve.

The client should be reminded that completion of any portion of this plan is voluntary and only offered to be helpful. There is no penalty if a client declines to use or follow up on any parts of this plan. It is mandatory, however, for providers to offer a Family Support Plan/Plan of Safe Care to clients, and to provide warm referrals, wherever available.

Confidentiality and Purpose of the Plan:

Confidentiality: The Family Support Plan/Plan of Safe Care is primarily designed to organize and facilitate access to services that help parents in early recovery or who are using substances. However, this plan may offer useful information to the Department of Children and Families, or other involved providers. Clients should be educated about their right to privacy, and encouraged to complete releases of information so that a Family support plan/Plan of Safe Care may be shared with DCF or other providers involved in their care. Sample releases of information that are compliant with 42 CFR privacy guidelines are attached to the back of this plan. ***Even in the absence of a release of information, it is important for providers to tell the Department of Children and Families that a plan was offered or created, whether or not DCF is currently involved with the family. They should also tell the Department whether any referrals were made to the family. They should do this without giving specific details - unless a confidentiality release has been signed.***

Purpose of the Family Support Plan/Plan of Safe Care: The Family Support Plan/Plan of Safe Care is designed to help families access the services they may need to prepare for parenting. It also may be used to show to the Department of Children and Families a concerted effort to engage in substance use treatment and recovery and provide a safe and healthy home for their children. This plan is one example of a comprehensive Plan of Safe Care. Providers or local communities may design their own Plan of Safe Care. DCF's Action Plan and EI's Individualized Family Services Plan also serve as Plans of Safe Care.

Date: _ _ / _ _ / _ _ _ _

I. Family and Primary Contacts:

My name_____ DOB _____ Phone Number _____

Relationship to child (or unborn child) _____ Okay to Text? ☐ Yes ☐ No

Street Address _____ City/Town _____ State _____ Zip _____

If pregnant: Due Date: _____ Date of First Prenatal Care _____

Any pregnancy complications: _____

If postpartum/parent or guardian: Child's Name: _____ Date of Birth _____

Who is the child living with now: _____

My main support person_____ Phone Number _____ Okay to Text? ☐ Yes ☐ No

Relationship to you and your child _____

Street Address _____ City/Town _____ State _____ Zip _____

Please consider signing releases so your main support person can communicate with others on your team.

In Case of Emergency, who would you want to take care of your child?

Name_____ Phone Number _____

Relationship to you and/or your child _____

Other Household Members (Who else is living in your home with you and/or your infant):

Name_____ Phone Number _____

Relationship to you and/or your child _____

Name_____ Phone Number _____

Relationship to you and/or your child _____

Name_____ Phone Number _____

Relationship to you and/or your child _____

Your other children:

Name _____ Birthday_____ Living with _____

Name _____ Birthday_____ Living with _____

Name _____ Birthday_____ Living with _____

Name _____ Birthday_____ Living with _____

Date: _ _ / _ _ / _ _ _ _

II. Who Else Is on Your Team?

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 DCF 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?)*	**Agency** *(Or relationship)*	**Name**	**Phone numbers**	**Other contact information** *(e.g. email, best time to call, etc.)*	**Next Appt Date**	**Progress Notes (Include Date)**
Example: Peer Support	Recovery Coach	Angela Example	(413) 555-0123	a.example@googles.com	8/25/18	Working on coping skills
Primary Care Doctor						
OBGYN/Prenatal Care Provider						
Counselor / Therapist						
Social Worker						
Psychiatrist/ Prescriber						
MAT Provider						
Child's Pediatrician						
Substance Use Treatment Provider						
Probation Officer						
DCF Case Worker						

Date: _ _ / _ _ / _ _ _ _

III. What Other Support Services Are You Receiving or Would You Like to Receive?

Support Service	Currently Receiving	Date Begun Services	Provider Agency Name and Phone Number	Would Like to Receive	Date of Referral (if made)
Substance Use and Mental Health Treatment and Support					
Medication Assisted Treatment	☐Yes ☐ No			☐Yes ☐ No	
Peer Recovery or 12-Step Support	☐Yes ☐ No			☐Yes ☐ No	
Mental Health Treatment / DMH Services	☐Yes ☐ No			☐Yes ☐ No	
Substance Use/Addiction Treatment	☐Yes ☐ No			☐Yes ☐ No	
Recovery Coach	☐Yes ☐ No			☐Yes ☐ No	
Recovery Support Center	☐Yes ☐ No			☐Yes ☐ No	
Disability or MassRehab Support	☐Yes ☐ No			☐Yes ☐ No	
Anger Management Services	☐Yes ☐ No			☐Yes ☐ No	
Public Benefits and Supports					
Women/Infants/Children Food Support (WIC)	☐Yes ☐ No			☐Yes ☐ No	
SNAP	☐Yes ☐ No			☐Yes ☐ No	
Transportation Assistance	☐Yes ☐ No			☐Yes ☐ No	
TANF or Financial Assistance	☐Yes ☐ No			☐Yes ☐ No	
Job Readiness or Educational Support	☐Yes ☐ No			☐Yes ☐ No	
Child Care Assistance	☐Yes ☐ No			☐Yes ☐ No	
Housing Assistance	☐Yes ☐ No			☐Yes ☐ No	
Legal Assistance	☐Yes ☐ No			☐Yes ☐ No	
Utility Payment Assistance	☐Yes ☐ No			☐Yes ☐ No	
Wellness, Health Information or Supports					
Doula / Labor Support	☐Yes ☐ No			☐Yes ☐ No	
Tobacco / Smoking Cessation Support	☐Yes ☐ No			☐Yes ☐ No	
Fitness, Nutrition, or Health Coaching	☐Yes ☐ No			☐Yes ☐ No	
Family Planning / Sexual Health	☐Yes ☐ No			☐Yes ☐ No	
Community or Social Supports					
Faith or Cultural Support	☐Yes ☐ No			☐Yes ☐ No	
Parent Support Groups	☐Yes ☐ No			☐Yes ☐ No	
Home Visitor (Early Head Start, Healthy Families, Parents as Teachers, etc.)	☐Yes ☐ No			☐Yes ☐ No	
Early Intervention (EI) or EIPP	☐Yes ☐ No			☐Yes ☐ No	
Relationship Violence Support	☐Yes ☐ No			☐Yes ☐ No	
Support Exiting Sex Work or Exploitation	☐Yes ☐ No			☐Yes ☐ No	
Support Exiting Gang or Street Life	☐Yes ☐ No			☐Yes ☐ No	

Date: _ _ / _ _ / _ _ _ _

Support Service	Currently Receiving	Date Begun Services	Provider Agency Name and Phone Number	Would Like to Receive	Date of Referral (if made)
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	
	☐Yes ☐ No			☐Yes ☐ No	

Date: _ _ / _ _ / _ _ _ _

IV. Support Plan: Parent

Things to do:

☐ Go to prenatal and after-birth doctor appointments	☐ Tour the Birth Hospital if pregnant, and meet with the Doctors and Nurses
☐ Set up a safe living environment for you and baby, free from drug/alcohol use, and without inside cigarette or marijuana smoke (including vaporizers!)	☐ Set up a safe Sleep environment (a crib with NO bumpers, no blankets, no toys; only a firm matress with a tight-fitting sheet)
☐ Plan how you're going to get support after birth, including babysitting, recovery support, transportation, etc.	☐ Schedule a Pediatric Appointment for your baby
☐ Ask your doctor about family planning or pregnancy prevention	☐ Find Parent Support groups, child-friendly 12-step meetings, or Mommy-and-Me gatherings in your area
☐ Get a referral for Early Intervention and Home Visiting Services	☐ Get **all** of your questions answered (about rooming-in with your baby, breastfeeding, the DCF process, all of it!) Keep asking questions!
☐	☐
☐	☐

Things to bring to hospital at delivery, for DCF:

☐ Records of your prenatal care visits	☐ Records of your addiction treatment (including drug screens)
☐ Relapse prevention and safety plans	☐ Signed letters of consent allowing DCF to talk to your treatment providers
☐ Written record of the work you've done to prepare to parent (classes you've taken, groups you've attended, etc.)	☐ A copy of THIS Family Support Plan or something simiar (Your ***Plan of Safe Care***).
☐	☐
☐	☐

Stay connected with your treatment providers and recovery community!
Ask for help. Every new parent needs help.
And there is so much help and support available to you, even when you don't think there is.

Date: _ _ / _ _ / _ _ _ _

V. Support Plan: Child

Child's Name: _____ Date of Birth _____ Living arrangement: _____

Insurance Type: _____

Child's Pediatrician (Name/Practice): _____ Phone: _____

Address: _____

How long did the baby stay in hospital after birth? _____

Any Medical Diagnoses: _____

Medications (with Dose and Dates of Prescription): _____

_____

Known Allergies: _____

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.

Well Child Visit Schedule	Date	Provider Name	Notes
2-5 days after hosp. Discharge			
1 month of age			
2 months of age			
4 months of age			
6 months of age			
9 months of age			
12 months of age			

Immunizations:

_____ Date Received: _____
_____ Date Received: _____
_____ Date Received: _____
_____ Date Received: _____

_____ Date Received: _____
_____ Date Received: _____
_____ Date Received: _____
_____ Date Received: _____

Ask for Referrals to:

Early Intervention (or EI) is a voluntary home visiting program for infants and toddlers that provides family-centered services to support your parenting and your child's development. You can ask the hospital, your baby's doctor, or a social worker to refer you to EI. Also, you can call the EI office yourself. To learn more about EI, call the Central Directory at 1-800-905-8437, or visit www.massfamilyties.org for a listing of EI programs near your city or town.

Home Visiting Services are available across the state, with different programs offered in different areas. Ask your provider what is available in your area, or visit the Home Visiting website: https://www.mass.gov/prenatal-and-early-childhood-home-visiting

Date: _ _ / _ _ / _ _ _ _

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize
(Name of patient)

_____
(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information:

_____
(Nature and amount of information to be disclosed, as limited as possible)

_____

The purpose of the disclosure authorized in this consent is to:

_____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: _____

_____ _____
Signature of patient Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____