One Page / Cover Page Template: Plan of Safe Care

This Plan of Safe Care Cover Page lists the people who are on your team. It is your choice whether to share this information with your providers and with DCF. The goal is to ensure coordination among providers caring for you and your newborn, and to show DCF the team of support that you have built. Fill this page out with the help of a trusted provider, and make sure you receive referrals to any services or supports you need throughout your pregnancy and after birth. Use the Plan Of Safe Care resource map (https://healthrecovery.org/resource-search/) and the Journey Recovery Project (journeyrecoveryproject.com) to learn about substance use, pregnancy, parenting, and available supports in your area. You can choose to make copies of the Release of Information form on the back of this page, and give permission for your providers to speak to each other and to DCF about specific aspects of your recovery and parenting preparation work. Ask to be included in those conversations if you want. You deserve honesty and support.

Your name _____ DOB _____ Phone number _____ Is this your cell phone? ☐ Yes ☐ No

Current address: Street _____ City/town _____ State _____ Zip _____ Email _____

Can you receive mail here? ☐ Yes ☐ No Is this a shelter or treatment program? ☐ Yes ☐ No If yes, program name _____

Due date or child's birthdate _____ Ages of other children you care for: _____

Your main support person's name _____ Relationship to you _____ Phone number _____

Is this a person you view as able to support/assist in providing safe care to your child/children? _____

Please consider signing consent forms so that your providers and DCF can communicate with your support person. (Release of Information Form on back.)

Current Services: (*fill in provider or program name(s), contact information, and whether there is a consent form signed for them to be able speak with DCF*)

Prenatal care _____ Phone number _____ Email_____ Consent signed ☐Yes ☐No

Parenting support _____Phone number _____ Email_____ Consent signed ☐Yes ☐No

Substance use treatment _____ Phone number _____ Email_____ Consent signed ☐Yes ☐No

Recovery support _____ Phone number _____ Email_____ Consent signed ☐Yes ☐No

Mental Health treatment_____ Phone number _____ Email _____ Consent signed ☐Yes ☐No

Pediatrician_____Phone number _____ Email _____ Consent signed ☐Yes ☐No

EI/VNA_____Phone number _____ Email _____ Consent signed ☐Yes ☐No

Other: _____ Consent signed ☐Yes ☐No

Were you given referrals for services for ***your recovery, health, or wellbeing*** during the process of developing this Plan of Safe Care? ☐Yes ☐No

Were you given referrals for services for ***your child or for parenting*** during the process of developing this Plan of Safe Care? ☐Yes ☐No

Were you given information about ***safe sleep***? ☐Yes ☐No If applicable, were you given information about ***overdose prevention***? ☐Yes ☐No

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 _____