Fairfield County Ohio Plan of Safe Care (POSC)

Date: _____/_____/_____

This Plan of Safe Care is a living document designed to support the well-being of this mother and her family throughout her maternal journey. It serves as a source of information and reassurance, ensuring that she and her care team have a shared understanding of her needs, strengths, and available resources. By fostering collaboration and empowerment, this plan helps create a safe, supportive environment for both the mother and her infant.

A copy of this Plan of Safe Care (POSC) will be housed at the Family and Children First Council located at 831 College Avenue, Suite C, Lancaster Ohio 43130. 740-652-7286

Section 1: Personal Information

Name:	Date of Birth:	Age:	
Address:	City:	State:	Zip:
Phone Number:	Email:		
Emergency Contact:	Relation:	Emergency Contact's Phone:	
Guardian (Minor):	Relation:	Guardian's Phone:	
Insurance: ☐ Aetna ☐ Aetna OhioRise ☐ AmeriHealth ☐ Anthem ☐ Buckeye ☐ Caritas ☐CareSource ☐ Humana ☐ Molina ☐ United Health Care			Private Plan:

Section 2: Family (*Please list all the people in your home.)*

	Name	Relationship	Date of Birth
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Section 3: Support Person(s) *(Someone you trust to help you and/or your children.)*

	Name	Relationship	Phone Number
1			
2			
3			

Section 4: Medical Information

Are you currently Pregnant? ☐ Yes ☐ No		Due Date:		Date of Initial (1st) Visit:	
OB/GYN:		Preferred Hospital or Birthing Facility:			
Current Medical and Mental Health Diagnoses		Medications		Primary Care Physician:	
1		1		Do you have a ***current*** substance use? ☐ Yes ☐ No Substance: _____ How long have you used this substance? _____ ☐ *NA*	
2		2			
3		3			
4		4			
5		5		Do you have a ***history*** of a substance use? ☐ Yes ☐ No Substance: _____ How long did you use this substance? _____ ☐ *NA*	
6		6			
7		7			
8		8			
9		9		Date of last use:	
10		10			
Medication Assisted Treatment (MAT) ☐ Yes ☐ No				Allergies:	

Section 5: Substance Use Recovery Plan ☐ *NA*

Current Treatment Program/Agency:	
Program/Agency Phone Number:	Address:
Counselor/Therapist:	Case Manager: ☐ *NA*
Have you created a plan in case you return to use? ☐ Yes ☐ No	Do you have a copy of the plan? ☐ Yes ☐ No

Comments:

Section 6: Health & Safety Plan for your infant.

Does your infant have a pediatric home? ☐ Yes ☐ No	Pediatrician/Health Care Provider:	
Is your baby up to date on their immunizations? ☐ Yes ☐ No		
Does your infant have equipment for safe sleep? ☐ Yes ☐ No If yes, what? _____	Infant's Medical Diagnoses	Infant's Medications
Does your infant have a car seat? ☐ Yes ☐ No How old is it? _____	*1.*	*1.*
Have you discussed feeding your infant with a professional. ☐ Yes ☐ No	*2.*	*2.*
Do you have childcare for when you return to work? ☐ Yes ☐ No Who:	*3.*	*3.*
Who will be helping you care for your baby at home? Who:	Do you have any concerns about your child's development? ☐ Yes ☐ No	

Additional Infant or Child Information:

Section 7: Resource

Possible Resources	Currently Engaged	Support Needed	Service Provider
(DAILY LIVING)			
Employment			
Housing			
Transportation			
Medical Insurance			
(TODDLER/CHILD)			
Childcare			
Dental Home			
Medical Home			
Mental Health			
Preschool/Education			
(INFANT)			
Breastfeeding Support			
Childcare			
Medical Home			
Parent Education			
(MEDICAL)			
Dental Home			
Medical Home			
Obstetrician/Gynecology Home			
Substance Use Disorder Treatment (SUD)			
(MENTAL HEALTH)			
Case Manager			
Counselor			
Crisis Line			
Recovery Support			
Domestic Violence Support			
(NUTRITION)			
SNAP (Supplemental Nutrition Assistance Program)			
WIC (Women, Infants & Children)			

Section 8: Referrals Made

Date	Agency	Support Needed	Who made the referral?

Section 9: Stress Management and Selfcare

Has someone spoken to you about postpartum depression? *Who?*	☐ Yes ☐ No
Has someone spoken to you about the needs of an infant exposed to substances in utero? *Who?*	☐ Yes ☐ No
Do you have a plan for when your infant is unable to be soothed, and you are feeling overwhelmed? Explain:	☐ Yes ☐ No
Do you have supportive family members who live with you and who will help you with your infant? *Who?*	☐ Yes ☐ No
Do you have supportive family members who live nearby that will help you with your infant, if you ask? *Who?*	☐ Yes ☐ No
Do you have friends or neighbors who live nearby and who will help you with your infant, if you ask? *Who?*	☐ Yes ☐ No
If you are alone and feeling stressed, is there something that you can do (at your home) to help you manage your stress?	☐ Yes ☐ No
What?	

Other questions or concerns:

Section 10: Current Support Agency List

Agency	Contact Name	Phone Number	Email
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Section 11: Acknowledgement

This Plan of Safe Care document is shared with the agencies that you are working with or have requested to work with and with your planned birthing facility or hospital to help support you and your baby's health, safety and overall wellbeing. An updated Release of Information will be sent along with your **P**lan **o**f **S**afe **C**are document. This Plan of Safe Care will be valid during your pregnancy and until your infant's first birthday.

*An agency I do not wish to share with: _____

Mother's Signature: _____ Date: _____/_____/_____

Professional Staff: _____ Date: _____/_____/_____

Professional Staff's Printed Name:_____

Title: _____ Agency: _____

Updated: *(Please make names legible)*

Date: _____ Name: _____ Date: _____ Name: _____

Date: _____ Name: _____ Date: _____ Name: _____

Date: _____ Name: _____ Date: _____ Name: _____