



MY PLAN OF SAFE CARE

**Developed with the support of my:
(Check all that apply)**

HOME VISITOR

PEER NAVIGATOR

PRENATAL CARE PROVIDER

CHILD WELFARE CASE MANAGER

**SUBSTANCE USE TREATMENT
PROVIDER**

OTHER:



My Plan of Safe Care

This plan belongs to:

Pregnancy and parenthood are special times when you make plans to care for yourself and your baby.

A Plan of Safe Care can be especially helpful during this time. Your service providers can support you in creating your plan.

This plan is designed to help you:

- Make decisions on how you will take care of yourself, your baby, and your family.
- Think about the people who can help.
- Consider the information and resources you can gather to create a strong safety net of support for your family.

Personal and Family Strengths: *In the text box, list you and your family's strengths.*

Goals: *For each of the categories below, write down things you are doing well and where you can grow. Take time to reflect on these and decide if a goal for each category will be a good place to begin your plan.*

	WHAT I'M DOING WELL	OPPORTUNITIES FOR GROWTH	MY GOALS
<i>Family & Friends</i>			
<i>Parenting</i>			
<i>Work/School</i>			
<i>Body</i>			
<i>Mental Health</i>			
<i>Recovery Journey</i>			
<i>Other:</i>			



To care for myself and my family, and to achieve my goals, I would like help with:

Basic Needs:

- | | | |
|--|---|---|
| <input type="checkbox"/> Housing and/or Utility Assistance | <input type="checkbox"/> Food | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Care Coordination | <input type="checkbox"/> Postpartum Supplies (e.g., hygiene kits, breast pumps, etc.) | <input type="checkbox"/> Other: |

Behavioral Health:

- | | | |
|---|---|--|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Substance Use Counseling | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Recovery Supports (e.g., 12-step group, Narcotics Anonymous (NA), Alcoholics Anonymous (AA), etc.) | <input type="checkbox"/> Medication Assisted Treatment |
| <input type="checkbox"/> Other: | | |

Physical Health

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Primary Medical | <input type="checkbox"/> Prenatal Care Provider | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Other: | |

Education Support

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Education | <input type="checkbox"/> Legal Assistance |
| <input type="checkbox"/> Other: | | |

Parenting & Family Support:

- | | | |
|--|--|---|
| <input type="checkbox"/> Birth Plan | <input type="checkbox"/> Safe Sleep Education | <input type="checkbox"/> Infant Development |
| <input type="checkbox"/> Lactation Support | <input type="checkbox"/> Evidence-Based Home Visiting | <input type="checkbox"/> Childcare |
| <input type="checkbox"/> Caring for my Baby | <input type="checkbox"/> <i>Early On</i> [®] | <input type="checkbox"/> Bonding/Attachment |
| <input type="checkbox"/> Eat, Sleep, Console | <input type="checkbox"/> Items for My Baby (e.g., car seat, crib, diapers, etc.) | <input type="checkbox"/> Parenting Classes |
| <input type="checkbox"/> Doula | <input type="checkbox"/> Social Connections (e.g., parenting groups, religious support, cultural groups, etc.) | <input type="checkbox"/> Other: |

Safety:

- | | | |
|--|---|---|
| <input type="checkbox"/> Domestic Violence or Feeling Unsafe at Home | <input type="checkbox"/> Home Environment (e.g., non-working smoke alarms, exposed wires, lead paint, etc.) | <input type="checkbox"/> Legal Assistance |
| <input type="checkbox"/> Safe Storage Options for Substances, Medications, Weapons, etc. | | <input type="checkbox"/> Other: |



As their partner or additional caregiver, I would like help with:

Basic Needs:

- | | | |
|--|---|---|
| <input type="checkbox"/> Housing and/or Utility Assistance | <input type="checkbox"/> Food | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Care Coordination | <input type="checkbox"/> Postpartum Supplies (e.g., hygiene kits, breast pumps, etc.) | <input type="checkbox"/> Other: |

Behavioral Health:

- | | | |
|---|---|--|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Substance Use Counseling | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Recovery Supports (e.g., 12-step group, Narcotics Anonymous (NA), Alcoholics Anonymous (AA), etc.) | <input type="checkbox"/> Medication Assisted Treatment |
| <input type="checkbox"/> Other: | | |

Physical Health

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Primary Medical | <input type="checkbox"/> Prenatal Care Provider | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Other: | |

Education Support

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Education | <input type="checkbox"/> Legal Assistance |
| <input type="checkbox"/> Other: | | |

Parenting & Family Support:

- | | | |
|--|--|---|
| <input type="checkbox"/> Birth Plan | <input type="checkbox"/> Safe Sleep Education | <input type="checkbox"/> Infant Development |
| <input type="checkbox"/> Lactation Support | <input type="checkbox"/> Evidence-Based Home Visiting | <input type="checkbox"/> Childcare |
| <input type="checkbox"/> Caring for my Baby | <input type="checkbox"/> <i>Early On</i> [®] | <input type="checkbox"/> Bonding/Attachment |
| <input type="checkbox"/> Eat, Sleep, Console | <input type="checkbox"/> Items for My Baby (e.g., car seat, crib, diapers, etc.) | <input type="checkbox"/> Parenting Classes |
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Safety:

- | | | |
|--|---|---|
| <input type="checkbox"/> Domestic Violence or Feeling Unsafe at Home | <input type="checkbox"/> Home Environment (e.g., non-working smoke alarms, exposed wires, lead paint, etc.) | <input type="checkbox"/> Legal Assistance |
| <input type="checkbox"/> Safe Storage Options for Substances, Medications, Weapons, etc. | | <input type="checkbox"/> Other: |



My Plan of Safe Care Continued

This plan belongs to:

My Providers

PROVIDER	NAME	CONTACT INFORMATION
Primary Care Provider		
Prenatal Care Provider		
Pediatrician		
Substance Use Treatment Provider		
Home Visitor		
Child Welfare Case Manager		
Mental Health Provider/Counselor		
Other:		

My Support System: Please list anyone in your life who can support you. This could include your partner, friends, family members, health care providers, spiritual advisors, emergency childcare contact, home visitor, groups you are a part of such as AA or NA, etc.

NAME	RELATIONSHIP/ROLE	CONTACT INFORMATION

Be Kind to Yourself

You have many positive qualities and deserve to be your best self. Remember there may be tough times as you work toward making a thriving life for you, your family, and your baby. We are all in the process of learning different life skills to be happier and healthier. Judgment and unkindness—even when it's from ourselves—only stands in the way. As your journey continues, so will your confidence in yourself to care for you and your family.



MY FAMILY WELLNESS PLAN

If you choose to commit to recovery and reduce your use of substances, there may be bumps in the road. It is important to think through coping strategies ahead of time so that when you may be feeling triggered, you are ready to respond. Additionally, identifying people who can support you and your children is essential in ensuring your family's overall wellness. You can complete this wellness plan with the support of a home visitor or another trusted person.

MY WARNING SIGNS ARE:

These can be thoughts, feelings or behaviors that suggest you may be at risk of returning to use of substances.

MY EFFECTIVE COPING STRATEGIES ARE:

These are things you can do to help lift your mood, like meditation or exercise.

MY SUPPORTERS:

Person 1:

Phone Number:

Person 2:

Phone Number:

Person 3:

Phone Number:

HOW MY SUPPORTERS CAN HELP ME:

What I need done:

Who I would like to do it:

STEPS I CAN TAKE TO MAKE MY ENVIRONMENT SAFER:

-
-
-
-
-

WHO CAN HELP WITH MY CHILDREN? FOR EXAMPLE, CHILDCARE, TRANSPORTATION, FOOD, CLOTHING, ETC.

IN THE EVENT OF A CRISIS:

Call Emergency Contact #1:

Call Crisis Hotline:

Call Emergency Services:



