**Supportive Care for Families and Infants**

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| 1. **PLAN OF SAFE AND SUPPORTIVE CARE (POSC)**
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| This POSC is developed collaboratively with all birthing parents and co-parents to reinforce and coordinate supports and services. The POSC must be given to the mother upon discharge from the birthing facility and should go to the infant’s primary care provider along with the infant’s other medical records. For an electronic version of this form, visit: <https://nhcenterforexcellence.org/posc/> . |

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| 1. **DEMOGRAPHIC INFORMATION**
 |
| Name of Birthing Parent: | Birthing Parent’s Medical Providers: |
| Name of Co-parent:  | Infant’s Medical Providers: |
| Name of Infant: | Birthing Parent’s Admission Date: |
| Name of Other Caregiver (if relevant): | Birthing Parent’s Discharge Date:  |
| Infant’s DOB: | Infant’s Discharge Date: |
| Birthing Parent’s Phone Number: | Co-Parent’s Phone Number: |
| Birthing Parent’s Health Insurance: | Other Caregiver’s Phone Number: |
| Current Address: |

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| 1. **CURRENT Supports** (such as partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)
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| 1. **Strengths and Goals** (*What matters to you?* Breastfeeding, parenting, housing, smoking cessation, recovery?)
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| 1. **HOUSEHOLD MEMBERS**
 |
| Name | Relationship to Infant | Age |  | Name | Relationship to Infant | Age |
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| 1. **EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS**
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| Name | Relationship to Infant  | Phone Number |
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| **VII. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE BIRTHING PARENT?** |
| Name: | Relationship to Infant: | Court Involvement (Y/N): |
| Phone Number/Address: |

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| **VIII. NOTES: What else would be helpful to you and your family?** (please time/date entries) |
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| **IX. SERVICES, SUPPORTS and NEW REFERRALS** |
|  | Discussed | Active | Referred | Organization/Contact Name/Phone Number  |
| Consents signed for exchange of PHI |  |  |  |  |
| ***Health Insurance*** |
| Commercial Insurance  |  |  |  |  |
| Medicaid |  |  |  | AmeriHealth Caritas Bright Start Program 1-833-704-1177NH Healthy Families Smart Start for Babies 1-866-769-3085Well Sense Health Plan Sunny Start Program: 1-855-833-8119 |
| Uninsured / Enrolled in Insurance |  |  |  |  |
| ***Financial Assistance*** |
| Women, Infants, and Children Program (WIC) |  |  |  |  |
| Temporary Assistance for Needy Families (TANF) |  |  |  |  |
| ***Family Supports*** |
| Early Supports and Services (FCESS) |  |  |  |  |
| Visiting Nurse Association (VNA) |  |  |  |  |
| Family Resource Center (FRC) |  |  |  |  |
| Home Visiting for Families  |  |  |  |  |
| Division for Children, Youth and Families |  |  |  |  |
| ***Other Healthcare Services*** |
| Lactation Services |  |  |  |  |
| Family Planning |  |  |  |  |
| Parenting Classes |  |  |  |  |
| Safe Sleep Education |  |  |  |  |
| Breastfeeding Education |  |  |  |  |
| Substance Use Education |  |  |  |  |
| ***Crisis Supports*** |
| NH Legal Assistance |  |  |  |  |
| Safety Advocacy |  |  |  |  |
| Probation/Parole |  |  |  |  |
| ***Treatment & Recovery*** |
| Mental Health Services |  |  |  |  |
| Alcohol/Drug Treatment |  |  |  |  |
| Drug Court  |  |  |  |  |
| Medication for Substance Use Disorder |  |  |  |  |
| Smoking Cessation |  |  |  |  |
| Naloxone (Narcan) |  |  |  |  |
| Recovery Coaching |  |  |  |  |
| Meetings |  |  |  |  |
| ***Other Supports*** |  |  |  |  |
| Transportation  |  |  |  |  |
| Housing  |  |  |  |  |
| Childcare  |  |  |  |  |

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| 1. **PARENT/CAREGIVER SIGNATURE**
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| I have a copy of my Plan of Safe and Supportive Care. I will share my POSC with my baby’s primary care provider, and I will call \_\_\_\_\_\_\_\_\_\_\_\_\_\_if I have any questions about following up with the services and supports listed above.**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **STAFF SIGNATURE**
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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_provided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with the Plan of Safe Care upon discharge.**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*This form complies with NH RSA 132:10-e and NH RSA 132:10-f.*