NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

PLAN OF SAFE CARE

Name of infant: _____ DOB: / /

Admission date: / / Discharge date: / /

Individual developing POSC:* _____ Individual monitoring POSC:* _____

Phone: ( ) _____ Phone: ( ) _____

Email: _____ Email: _____

Household Members and Affected Family or Caregivers of the Infant:

Name	Age	Relationship to infant	Name	Age	Relationship to infant

Post-Discharge Family Strengths and Goals: (e.g., breastfeeding, housing, smoking cessation, parenting support, recovery)

Identified Supports: (e.g., stable living environment, family and friends, employment, etc.)

Safety and Protective Factors Present: (e.g., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children, etc.)

Family Is Currently Involved in the Following Services:

Service	Organization	Contact person/Phone/Email

New Family Services Referred or Recommended:

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email

**Plan of Safe Care (POSC)*

Comments:

Signature of parent /caregiver: _____

Date: / / Print name: _____

Signature of staff: _____

Date: / / Print name: _____

Review by (Date): / /