My Plan of Safe Care (POSC)
for Myself & My Baby

Name ______________________ Today's Date: __________

My Expected Delivery Date: ______________________

My Support Team

Person/People Helping Me Make This Plan:

Name: __________ Name: __________

Role: __________ Role: __________

Phone: __________ Phone: __________

Email: __________ Email: __________

My Friends/Family/Community:

Name: __________ Name: __________

Relationship: __________ Relationship: __________

Phone: __________ Phone: __________

Notes: __________ Notes: __________

Name: __________ Name: __________

Relationship: __________ Relationship: __________

Phone: __________ Phone: __________

Notes: __________ Notes: __________

My Healthcare Providers:

Prenatal Care Provider: __________ Phone: __________

Medical Care Provider: __________ Phone: __________

Medication for Addiction Treatment Provider: __________ Phone: __________

Pediatrician: __________ Phone: __________

My Healthcare Provider: __________ Phone: __________

Additional Providers: __________ Phone: __________

Additional Providers: __________ Phone: __________

My Plan of Safe Care (POSC) for Myself & My Baby

My Goals for Myself & My Newborn

Goal ______________________________

Type of Assistance:	Who Can Help?
☐ Breastfeeding	
☐ Medication for Addiction Treatment	
☐ Recovery	
☐ Counseling	
☐ Job	
☐ Housing	
☐ Education	
☐ Parenting Skills	

Other:

☐	
☐	
☐	
☐	
☐	
☐	

My Plan of Safe Care (POSC)
for Myself & My Baby

My Strengths:

My Thoughts: