NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Nebraska Plan of Safe Care for Providers

Name of Infant:	DOB:	Admission Date:	Discharge Date:
Mother's Name:		Infant's Primary Caregiver:	
Infant's PCP:			

Household Members:

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

Identified Supports (Grandparent, Neighbor, Aunt...):

Prenatal Exposure:

Methadone/Buprenorphine (MAT)	
Prescribed opioids for chronic pain	
Prescribed benzodiazepines	
Marijuana	
Nicotine/tobacco	
Alcohol	
Methamphetamine	

Other:	
Other:	
Other:	

Check box(es) for all applicable services and new referrals for infant and mother/caregivers:

	Discussed	Current	New Referral	Organization	Contact Person (if applicable)
Mental Health Treatment	☐	☐	☐		
Substance Use Treatment	☐	☐	☐		
Recovery Supports	☐	☐	☐		
Smoking Cessation	☐	☐	☐		
Parenting Groups	☐	☐	☐		
Home Visiting	☐	☐	☐		
WIC/SNAP	☐	☐	☐		
Respite	☐	☐	☐		
Financial, Transportation, Housing Assistance	☐	☐	☐		
Childcare or Childcare Subsidy	☐	☐	☐		
Safe Sleep	☐	☐	☐		
Crying Plan	☐	☐	☐		
Early Development Network	☐	☐	☐		
Domestic Violence Support	☐	☐	☐		
Other	☐	☐	☐		

Post discharge Family Strengths and Goals (breastfeeding, housing, parenting, and recovery)

Comments:

☐ Family was involved in development of this plan.

Signature of parent/caregiver (optional): _____

Signature of staff: _____

Copy to: Primary Care Provider, Family

For additional questions: DHHS.CARANotification@nebraska.gov or 402-314-7166