Contact Information

Your name _____ DOB _____

Phone number _____ Is this your cell phone? ☐ Yes ☐ No

Current address: Street _____

City/town _____ State _____ Zip _____

Email _____ Can you receive mail here? ☐ Yes ☐ No

Is this a shelter or treatment program? ☐ Yes ☐ No If yes, program name _____

Due date or child's birthdate _____ Ages of other children _____

Your main support person's name _____

Relationship to you _____ Phone number _____

Is there a person you view as able to support/assist in providing safe care to your child/children? _____ Phone number _____

Please consider signing consent forms so that your providers and DCF can communicate with your support person. (Release of Information Form on sheet 6)

Current Services: (fill in provider or program name(s), contact information, and whether there is a consent form signed for them to be able speak with DCF)

Prenatal care _____ Phone number _____

Email _____ Consent signed? ☐ Yes ☐ No

Parenting support _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Substance use treatment _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Recovery support _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Mental health treatment _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Pediatrician _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Early Intervention _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Other _____ **Phone number** _____

Email _____ **Consent signed?** ☐ **Yes** ☐ **No**

Were you given referrals for services for ***your recovery, health, or wellbeing*** during the process of developing this Plan of Safe Care? ☐ **Yes** ☐ **No**

Were you given referrals for services for ***your child or for parenting*** during the process of developing this Plan of Safe Care? ☐ **Yes** ☐ **No**

Were you given information about ***safe sleep***? ☐ **Yes** ☐ **No**

If applicable, were you given information about ***overdose prevention?*** ☐ **Yes** ☐ **No**

Drug Screen Results Request

I requested a copy of my toxicology results on this date: _____ from this person

_____ (phone) _____

The test was completed by this agency: _____

Contact person: _____

Phone: _____

Address: _____

The test was performed on this (these) date(s): _____

☐ I have a copy of these results, attached to this plan.

☐ I have asked that a copy be sent to the: ☐ hospital social worker ☐ my DCF caseworker

☐ I have signed a Release of Information so that DCF can ask for a copy and see these results.

Letters of Support

Spend some time thinking about your work so far in your recovery. Who have you worked with, or who has seen the efforts you're making to progress in your recovery, have a healthy pregnancy, and plan for birth?

Even if you just began your recovery journey, you can ask one of your providers or recovery mentors to write a letter of support for you. They can write about how *recovery is always possible*, and that you will have their support and help during your pregnancy, and after the birth of your baby.

A letter of support doesn't have to be long, and it doesn't have to be from someone you've known a long time. It should say that they believe in you, and are willing to help you, as long as you are working on your recovery and parenting. (DCF may still want to speak with people in your life.)

If you cannot think of anyone to write you a letter of support, that's okay too. You don't have to include letters of support in your DCF Portfolio. And don't worry, you will build a community of support as you continue on your path of recovery and motherhood.

Maybe, as an exercise, you could try and write a letter of support to yourself. What would you say to yourself to encourage and reassure yourself? How would you offer help to yourself, if you were a friend? This can be a good way of identifying the strengths you already have, and naming the kinds of help and support that you need.

THERE ARE PROVIDERS AROUND THE STATE WILLING TO HELP AND SUPPORT YOU.

If you need treatment or recovery support services, visit the Massachusetts Substance Use Helpline: **helplinema.org**, 800-327-5050.

Refer to the ***People to Meet During Pregnancy Journey Guide*** (on page 2 of the Recovery and Wellness Plan) for tips on connecting with prenatal providers and birth hospitals.

Recovery Wellness Plan

Thoughts of relapse build up over time. Unless I change my thoughts and take action steps, thoughts of relapse can take me off my recovery pathway. I have to pay attention to my Emotions, Thoughts, and Behaviors.

EMOTIONS

Feelings that might take me off track: (add your own ideas and thoughts in the blanks)

- ☐ Anger
- ☐ Frustration
- ☐ Fear
- ☐ Sadness
- ☐ Loneliness
- ☐ Regret
- ☐ Tiredness
- ☐ Boredom

_____

_____

_____

_____

Things I can do to distract from, talk about, or change these feelings:

Distractions (get sleep; watch something funny): _____

_____

_____

People to talk to: _____

New thoughts or ideas that will challenge the negative feelings (gratitude list): _____

_____

_____

THOUGHTS

Thoughts that might take me off track:

- ☐ It wasn't that bad
- ☐ He's worth it
- ☐ I can't keep this up
- ☐ I can do just one
- ☐ No use/Too late for me
- ☐ No one cares
- ☐ No one will notice
- ☐ It's the only thing that will help me

_____

_____

_____

_____

Things I can do to distract from, talk about, or change these thoughts:

Distractions (eat; go for a walk): _____

_____

_____

People to talk to: _____

New thoughts or ideas that will challenge the negative thoughts (play the tape through to the end):

_____

_____

BEHAVIORS

Behaviors that might take me off track:

- ☐ Stealing
- ☐ Meeting up with unhealthy people
- ☐ Holding cash
- ☐ Not sleeping
- ☐ Hanging out in old spots
- ☐ Smoking cigarettes
- ☐ Skipping medications or appointments

_____

_____

_____

_____

_____

Things I can do to distract from, talk about, or change these behaviors:

Distractions (help someone): _____

_____

_____

People to talk to: _____

New thoughts or ideas that will challenge the negative behaviors (who I am is defined by how I act):

_____

_____

Child Wellness Plan

Taking care of the children who are in my custody is my priority. Here are the things I will do and have in place to make sure the children in my care are safe and healthy.

1 This Child Wellness Plan is prepared for the following child(ren): _____

_____

2 I have signed a Release of Information so that this plan can be shared with DCF: ☐ Yes ☐ No

3 I am committing to keeping the children in my care away from any substances and will not let them be cared for by any intoxicated people.

4 I have prepared a **safe sleep environment** for all children in my care under 1 year of age. They will always sleep:

- ☐ On a firm and flat mattress, in their own crib – not in a bed with anyone else
- ☐ In an empty crib, away from any cords, blankets, toys, or pillows
- ☐ In a well-ventilated, smoke-free room
- ☐ Dressed appropriately for the temperature, and placed on their backs

5 My child will see their doctor regularly, and I know who to call if I have questions or concerns about my child(ren)'s health.

- ☐ Name of their doctor and contact information: _____
- ☐ Who I will call if there is an emergency or if my child gets sick: _____

_____

6 I understand that I will need help and support while I am parenting. I have a team of friends and providers who can help me.

- ☐ Recovery support: _____
- ☐ Help with child care: _____
- ☐ Help getting supplies: _____
- ☐ Parenting information: _____

Other Ideas: _____

7 It is important that I learn about my child(ren), how they're growing, and how best to parent them. I will participate in the following groups, services, and activities to learn more about parenting.

- ☐ Parenting class or support service: _____
- ☐ Parenting support group or information resource: _____
- ☐ Other parenting support (including therapy for me): _____

Learn more about parenting in recovery at *https://journeyrecoveryproject.com/*

Find home visiting services in your area at *https://www.mass.gov/prenatal-and-early-childhood-home-visiting-programs*

Find early intervention services in your area at *https://www.massfamilyties.org/#EI*

_____ _____

Parent Signature Date

_____ _____

Witness Signature Date

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Children and Families
www.mass.gov/dcf

CONSENT TO DISCLOSE ALCOHOL AND DRUG TREATMENT INFORMATION

I, _____ give permission to the person(s) and/or organization
(Please print your name)
listed below to communicate and release to each other my confidential alcohol and/or drug treatment information for the purposes listed below. The people and organizations listed below cannot share with or re-disclose any confidential treatment information about me to any other individual or organization not listed below without my written permission, except as explained in Appendix A (attached to this form).

Individuals and Organizations allowed to communicate and disclose information to each other:

1. _____
(Treatment Provider)

2. The Department of Children and Families (the "Department")

Information that can be disclosed:

I give permission to the people and organizations listed above to communicate with and disclose to one another the following information:

☐ All information related to my treatment from the Treatment Provider whose name appears in #1 above and the Department.

OR

☐ Only the following information related to my treatment from the Treatment Provider whose name appears in #1 above: (Check all that apply)

- ☐ Initial evaluation
- ☐ Date of Admission
- ☐ Assessment
- ☐ Treatment plan, including progress and compliance
- ☐ Attendance
- ☐ Drug Testing
- ☐ Changes in address, household, composition or personal relationships
- ☐ Observations of interaction with children
- ☐ Discharge Plan, including date and status
- ☐ Other: (Specify) _____

☐ I give permission to DCF to share the following information to the Treatment Provider named above:

_____

_____

Purpose of the Authorization:

☐ DCF response, assessment, service provision and referral for services

☐ Other: (Specify) _____

Revocation of Authorization:

I understand that:

1. Information about my participation in an alcohol and/or drug treatment program is protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be revealed to anyone without my written approval unless otherwise allowed in federal regulations.
2. I can rescind or change this authorization at any time except to the extent that action has already occurred in reliance on it. I understand that the canceling or change will not apply to information that has already been released in accordance with to this authorization.
3. If I revoke this authorization, or change it in any way, I specifically authorize any person or organization named above to notify others individuals and providers, that I have revoked or changed this authorization.

Expiration: This authorization shall expire whichever occurs first: (Check one)

☐ 12 months from the date of signing, ☐ case closing, or ☐ otherwise specified date or event (Specify): _____

Your signature (Adults and Youth age 12+)	**Print your name**
Date of birth	**Date signed**

☐ I have received a copy of this Authorization.

☐ I am the person whose records will be used and/or disclosed. I give authorization/permission to use and/or disclose my records as described in this document.

☐ I am the authorized Personal Representative of the person whose records will be used and/or disclosed. My relationship to that person is: _____

Signature of Parent or Parent Representative	**Type of Authority (e.g., court appointed, custodial parent)**	**Date signed**

****

APPENDIX A

In addition to the person(s) and/or organizations that I have authorized to share/disclose information regarding my drug/alcohol treatment I understand that the Department may re-disclose information in the following circumstances:

Should a Care and Protection proceeding be filed, DCF is required to provide a copy of its entire record to all parties, (or their attorneys), to the Court Investigator and any Guardian Ad Litem (if one is appointed).

Massachusetts Law requires DCF to report criminal acts against children to the District Attorney's Office and Police. Examples of these required filings are when a child has died, been sexually assaulted or severely injured.

There are times when DCF's records are required to be brought to a court. Examples of these are criminal cases and Probate and Family Court.

The Office of the Child Advocate is authorized by statute to have access to certain Department records and has the ability to request and review un-redacted records when they believe it necessary.

The Department may also provide copies or portions of its records to other state agencies such as the Department of Youth Services, the Department of Elementary and Secondary Education or the Department of Early Education and Care. This is allowed by statute and/or regulations.