CHDFS, Inc. Waiver Safety Alert Plan (SAP)

307 West 38th Street, 6th floor NYC, NY, 10018 (212) 695-4564 Fax: (212) 695-4561 @www.chdfs.org

CHILD'S NAME, (LAST, FIRST, MI,):	GENDER: ☐ Male ☐ Female	DATE OF BIRTH: ___/___/_____
MEDICAID CIN #:	MCO:	Member ID (if applicable):

Type Of Safety Alert Plan
☐ **Safety Alert Plan (Initial)**: Developed within 30 days of the first face to face appointment with the child and family/caregiver. **Completed Date**: / /
☐ **Safety Alert Plan (Reviewed)**: To be completed when there is a need for significant change in the level or amount of service(s) or Within 6 months of the last SAP. **Completed Date**: / /

A Waiver Safety Alert plan (SAP) Is established when risk is indicated and created in collaboration with the child, family, service provider(s), those involved in the child's treatment and any additional resource or sources of support. Safety plans reflect the child/family's circumstances and preferences and may be modified over time.

Child Contact Information

Child's Full Current Address: ____

Caregiver/Parent's Name: ____

Caregiver/Parent's Phone Number: ____

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Health Home Care Management Agency: ____

Health Home Care Manager Name: ____

HH Care Manager Agency Phone Number: ____

School Name, Address, Contact Person and Phone Number:

____

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Health Information

Does the child have Mental Health and/or SED Diagnosis?

☐ Yes ☐ No ☐ Child/family prefer not to say.

If yes identify diagnosis (include diagnosis code): ____

Does the child have Medical Diagnosis?

☐ Yes ☐ No ☐ Child/family prefer not to say.

If yes identify Medical Diagnosis: ____

Does the child have Allergies?

☐ Yes ☐ No ☐ Child/family prefer not to say.

If yes identify Allergies: ____________

Does the child take Medication?

☐ Yes ☐ No ☐ Child/family prefer not to say.

If yes identify Medications and Dosages: _____

Are there any Functional Limitations/Impairments?

☐ Yes ☐ No ☐ Child/family prefer not to say.

If yes, identify Functional Limitations/Impairments _____

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Medical records

Has the child visited the ER (Medical and/or Mental Health) within the past year? ☐ Yes ☐ No

If yes, please provide dates and reason for the Visit: _____

Has the child been in an inpatient setting or Hospitalizations (Medical and/or Mental Health) within the past year: ☐ Yes ☐ No

If yes, please provide dates and reason for the Visit: _____

Risk Factors/History (I.E. Substance Abuse, Domestic Violence, Self-Harm, Suicide Attempts, Environmental Factors, etc.):

1. Illicit drug use ☐ Yes ☐ No Explain:
2. Suicide attempt ☐ Yes ☐ No When & How:
3. Hallucinations ☐ Yes ☐ No Explain:
4. Self-harm ☐ Yes ☐ No Explain:
5. Inappropriate ☐ Yes ☐ No Explain:
   Sexual Behavior

Formal Providers

Primary Care Physician Name and Contact Number (if applicable):

Therapist Name and Contact Number (if applicable):

Psychiatrist Name and Contact Number (if applicable):

Nearest Hospital (ED) Name and Contact Number:

Pharmacy Name and Contact Number (if applicable):

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CFTSS and/or HCBS Providers

Children and Family Treatment Support Services Providers:	**Home and Community-Based Services Providers:**
OLP: OLP Supervisor:	CH: CH Supervisor:
CPST: CPST Supervisor:	DH: DH Supervisor:
PSR: PSR Supervisor:	CSATS: CSATS Supervisor:
YPST: YPST Supervisor:	PR: PR Supervisor:
FPST: FPST Supervisor:	CR: CR Supervisor:
	CFSS: CFSS: Supervisor
	PVS: PVS Supervisor:
	SE: SE Supervisor:
	PC: PC Supervisor:

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Current Issues- Potential Triggers Personal/family/legal/social, etc.)

☐ Hearing "No"	☐ Crowds	☐ Lack of Structure
☐ Being Teased – Peers/Adults	☐ Being isolated	☐ Feeling Scared
☐ Being Touched	☐ Not Having Control	☐ Feeling Pressures
☐ Arguments	☐ People Yelling	☐ Boredom
☐ Feeling Lonely	☐ Loud Noises	☐ Peer Pressure

Others (describe):

Early Warning Signs that the Child is Becoming Upset

☐ Agitation	☐ Isolating/Withdrawing	☐ Verbal defiance
☐ Restlessness	☐ Not talking	☐ Rapid speech
☐ Sweating	☐ Not making eye contact	☐ Tangential thought process
☐ Shortness of breath	☐ Crying/teary eyed	☐ Not taking medication
☐ Pacing	☐ Clenching teeth	☐ Repetitive, ritualistic Behaviors

Other early warning signs (describe):

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Current Behaviors of Concern (within the last 90 days and where they happen)

☐ Cursing	☐ Destroying property	☐ Verbal aggression
☐ Fighting	☐ Running away	☐ Stealing
☐ Suicidal ideation	☐ Gang involvement	☐ Not following directions
☐ Cruelty to Animals	☐ Biting	☐ Fire setting
☐ Hitting		

Other specific behaviors (describe):

Where do behaviors of concern most often occur?

Intervention Strategies (what works?) and Child/Family Strengths

☐ Positive reinforcement	☐ Talking about feelings	☐ Ripping paper
☐ Exercise	☐ Writing about feelings	☐ Taking deep breaths
☐ Change for environment	☐ Drawing	☐ Counting to ten
☐ Listening to music	☐ Watching television	☐ Time alone
☐ Reading	☐ Playing games	☐ Punching a pillow (and/or mattress/sofa)
☐ Take a walk	☐ Leaving the situation	
☐ Talking to someone (Mom)		

Other specific interventions (describe):

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Other actions to be taken by family members present: If above actions do not help, family will call crisis phone: • CHDFS Waiver Hotline: (646) 626-1277 In addition, youth and or family can contact the following Hotlines: • 888- NYC-WELL (692-9355) • Text "WELL" to 65173 to communicate via text (Available 24/7 365 days of the year) • National suicide Prevention lifeline 1-800-273-Talk (8255) • Crisis Text Line by texting 741741 • 212-673-3000 Samaritans 24 hours' crisis hotline If the interventions listed above, do not deescalate the crisis and youth is in immediate danger too self or others family will call **911**.
Additional recommendations (if applicable):

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☐ I consent to have this document reviewed with my child's school.

☐ I do not consent to have this document reviewed with my child's school.

☐ I consent to have a copy of this document provided to my child's school.

☐ I do not consent to have a copy of this document provided to my child's school.

Required Signatures (for initial safety plan and for each updated safety plan)

Child: ______________________________________ Date: ___/___/_____

Parent/Caregiver: ____________________________ Date: ___/___/_____

Provider: ____ Date: ___/___/_____

Provider Supervisor: ______________________________ Date: ___/___/_____

Clinical Supervisor (if available) ____________________________ Date: ___/___/_____

Date Copy of Initial Safety Alert Plan and Updates Given to Family:

Date: ___/___/_____

Date Copy of Initial Safety Alert Plan and Updates Given to School (if required):

Date: ___/___/_____