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| Missouri State Seal | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **NEWBORN CRISIS ASSESSMENT TOOL (NCAT)** | | | | | | | | | | | | | | | | | |
| **CASE DATA** | | | | | | | | | | | | | | | | | | | |
| Referral Number | | | | County | | | | | | | | | | | Drug Involved  Non-Drug Involved | | | | |
| Case Name | | | | | | | | | | | | | | | | Children’s Service Worker | | | |
| Child’s Information | | | | | | | | | | | | | | | | | | | |
| Infant’s Name | | | | | | | | | | | | DOB | | | | | | | |
| Birth Weight | | | | | | | | | Gestational Age | | | Discharge Date | | | | | | | |
| **Parent’s Information** | | | | | | | | | | | | | | | | | | | |
| Mother’s Name | | | | | | | | | | | | Father’s Name | | | | | | | |
| Is Father on Birth Certificate?  Yes  No | | | | | | | | | | If no, was an affidavit signed by the alleged father?  Yes  No | | | | | | | | | |
| Additional Comments: | | | | | | | | | | | | | | | | | | | |
| **PRIOR HISTORY** | | | | | | | | | | | | | | | | | | | |
| No history  Prior Newborn Crisis Assessment on sibling(s)  Parents/caregivers have a history of abuse/neglect or previous CD case with protective services  History of children out of the home with relatives, friends, or foster care  Protective services case is currently open  CD investigation/assessment currently pending  Siblings currently placed out of the home  Siblings currently under court jurisdiction  Siblings have been Termination of Parental Rights  History of domestic violence  Prior history of safe sleep related incident, death of another child in the home or serious injury to another child in the home. | | | | | | | | | | | | | | | | | | | |
| Summary/Comments: | | | | | | | | | | | | | | | | | | | |
| **MEDICAL DOCUMENTATION** | | | | | | | | | | | | | | | | | | | |
| HOSPITAL | | | | | | | PHYSICIAN | | | | | | | | | | | PHONE | |
| HOSPITAL CONTACT PERSON | | | | | | | | | | | | | | | | | | PHONE | |
| **PRENATAL CARE** | | | | | | | | | | | | | | | | | | | |
| Regular prenatal care | | | | | | | | Prenatal Care Provider: | | | |  | | | | | | | |
| Inconsistent, late, or no prenatal care  Prenatal drug use  Unwanted pregnancy | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| Pregnancy Complications;  Yes  No | | | | | | | | | | | | | | | | | | | |
| Describe: | | | | | | | | | | | | | | | | | | | |
| **TOXICOLOGY AT BIRTH** | | | | | | | | | | | | | | | | | | | |
| Mom Urine Drug Screen | | | | | Infant Urine Drug Screen | | | | | | | | | Infant Meconium Drug Screen | | | | Cord Drug Screen | |
| Pending  Positive | | | Not done  Negative | | Pending  Positive | | | | | Not done  Negative | | | | Pending  Positive | | | Not done  Negative | Pending  Positive | Not done  Negative |
| Substances | | | | | Substances | | | | | | | | | Substances | | | | Substances | |
| Substances | | | | | Substances | | | | | | | | | Substances | | | | Substances | |
| Substances | | | | | Substances | | | | | | | | | Substances | | | | Substances | |
| Has the infant been identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or “a Fetal Alcohol Spectrum Disorder”?  Yes  No | | | | | | | | | | | | | | | | | | | |
| Withdrawal Symptoms:  None  Seizures/abnormal neurological findings  Uncontrolled crying, increased irritability, trembling  Abnormal GI, persistent feeding problems, watery stools  Mild sensory deficit, increased or decreased activity  Requires medication for withdrawal | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| **\*Note: When determining if an infant has been “affected” by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, Children’s Division staff shall assess if the child’s physical, mental, or general well-being is affected by the use of substances by the parent/caretaker and a Plan of Safe Care is needed.** | | | | | | | | | | | | | | | | | | | |
| **HEALTH CARE NEEDS OF INFANT** | | | | | | | | | | | | | | | | | | | |
| Special Health Care Needs of the Infant:  None  Infant on monitor, apnea  Low birth weight (below 2400 grams or 5 lbs)  Frequent medical follow-up needed  Special feedings needed  Special home care/treatment for infant | | | | | | | | | | | | | | | | | | | |
| **General Health Care Needs of the Infant:** | | | | | | | | | | | | | | | | | | | |
| Child has an identified pediatrician/primary care physician (PCP) | | | | | | | | | | | | | | | | | | | |
| Name of Pediatrician/PCP or NA if none identified at this time | | | | | | | | | | | | | | | | | | | |
| Child has medical coverage, i.e. Medicaid/insurance, | | | | | | | | | | | | | | | | | | | |
| Type of coverage or NA if no coverage at this time | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| **BEHAVIOR ASSOCIATED WITH DRUG AND ALCOHOL USE OF PARENT(S)** | | | | | | | | | | | | | | | | | | | |
| No observed or known behaviors associated with drug and alcohol use  Parent/caregiver admits to alcohol and/or drug use and is participating in a treatment program  Evidence of drug/alcohol use and is not participating in a treatment program  Prior treatment for drug/alcohol use  Sibling(s) exposed to drugs or alcohol in utero  Chemical use poses risk to family’s financial resources and affects ability to meet basic need of family  Friends or family members appear under the influence of drugs or alcohol  Drugs sold, used or made in the home | | | | | | | | | | | | | | | | | | | |
| What substance use worries exist? | | | | | | | | | | | | | | | | | | | |
| What is or has been successful in regard to treating your substance use? | | | | | | | | | | | | | | | | | | | |
| What support do you need to help you with your substance use? | | | | | | | | | | | | | | | | | | | |
| Scaling: On a scale of 0 to 10 where 10 is your substance use does not affect your ability to parent your infant and 0 you do not have the ability to parent your infant based on your substance use. | | | | | | | | | | | | | | | | | | | |
| What supports could be provided for you to increase your number? | | | | | | | | | | | | | | | | | | | |
| **MENTAL HEALTH OF PARENT(S)** | | | | | | | | | | | | | | | | | | | |
| No known mental health needs  Currently receiving mental health services  Postpartum Depression  Currently receiving physician assisted medication management for mental health needs  History of suicide attempts  Currently making suicidal gestures  Chronic emotional, problems which impair ability to provide minimal care or supervision to infant  Currently threatening to harm or actually harming the child  Inability to function independently  Not oriented to person, place, time  Evasive, verbally hostile or physically assaultive/threatening to service provider  Low cognitive functioning that would affect parent’s ability to take care of infant | | | | | | | | | | | | | | | | | | | |
| What mental health worries exist? | | | | | | | | | | | | | | | | | | | |
| What is or has been successful in regard to treating your mental health needs? | | | | | | | | | | | | | | | | | | | |
| What supports do you need to assist you with your mental health needs? | | | | | | | | | | | | | | | | | | | |
| Scaling: On a scale from 0 to 10, where 10 is your mental health needs do not affect your ability to parent and 0 you do not have the ability to parent your children based on your mental health needs. | | | | | | | | | | | | | | | | | | | |
| What supports do you need to increase your number? | | | | | | | | | | | | | | | | | | | |
| Domestic Violence reported in the household:  Yes  No  Comments: | | | | | | | | | | | | | | | | | | | |
| **ATTACHMENT AND BONDING** | | | | | | | | | | | | | | | | | | | |
| What are you worried about in regard to parenting your infant? | | | | | | | | | | | | | | | | | | | |
| What are you excited about in regard to parenting your infant? | | | | | | | | | | | | | | | | | | | |
| What support do you need to help you parent your infant? | | | | | | | | | | | | | | | | | | | |
| Observations of parent/child interaction and bonding: | | | | | | | | | | | | | | | | | | | |
| Scaling: On a scale of 0 to 10, where 10 is you have all the supports you need and feel prepared to parent your infant and 0 you do not have any supports and do not feel prepared to parent our infant. | | | | | | | | | | | | | | | | | | | |
| What supports could be provided to increase your number? | | | | | | | | | | | | | | | | | | | |
| **ASSESSMENT OF OTHER CHILDREN IN THE HOME** | | | | | | | | | | | | | | | | | | | |
| No other children residing in the home  Parent(s) meeting mental health needs of other children in the home  Parent(s) meeting educational needs of other children in the home  Parent(s) meeting medical needs of other children in the home  Parent(s) meeting physical needs of other children in the home, i.e., food, clothing, safe shelter, appropriate sleeping arrangements | | | | | | | | | | | | | | | | | | | |
| Summary of observations of other children in the home: | | | | | | | | | | | | | | | | | | | |
| **OBSERVATIONS OF INFANT’S HOME ENVIRONMENT** | | | | | | | | | | | | | | | | | | | |
| Observed supply of baby formula  Mother is breastfeeding.  Observed crib or bassinet for infant  Observed car seat for the infant  Observed baby supplies for infant, i.e. diapers, bottles, wipes, clothing  Observed food for others living in the home  Observed operable plumbing and electricity/heating in the home  Home free of physical or environmental hazards that might be dangerous for the infant  Home free of infestations of insects or rodents | | | | | | | | | | | | | | | | | | | |
| Describe infant’s sleeping environment: | | | | | | | | | | | | | | | | | | | |
| Parent(s) has been given the Safe Sleep Flyer (CD 278) and worker explained the importance of a safe sleeping environment for the infant. | | | | | | | | | | | | | | | | | | | |
| Parent has acknowledged and signed that they have received and understand the Safe Sleep Flyer (CD278). | | | | | | | | | | | | | | | | | | | |
| Referrals made to Family Support Division, WIC, First Steps, Home Visiting, Parents As Teachers, or other community agency as needed. | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| **PLAN OF SAFE CARE** | | | | | | | | | | | | | | | | | | | |
| Was a Plan of Safe Care developed with the family?  Yes  No  N/A | | | | | | | | | | | | | | | | | | | |
| Was a referral(s) made for appropriate services for the affected child or family member/caregiver?  Yes  No  N/A | | | | | | | | | | | | | | | | | | | |
| Describe services referred: | | | | | | | | | | | | | | | | | | | |
| A Plan of Safe Care should be inclusive of the following:   * Parents’ or infant’s treatment needs; * Other identified needs that are not determined to be immediate safety concerns; * Involvement of systems outside of child welfare * A plan that is able to continue beyond the child welfare assessment if a case is not opened for further services. | | | | | | | | | | | | | | | | | | | |
| Plan of Safe Care: | | | | | | | | | | | | | | | | | | | |
| Who was involved with creating the Plan of Safe Care? | | | | | | | | | | | | | | | | | | | |
| Were all involved with creating the Plan of Safe Care in agreement with the plan?  Yes  No | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| **SAFETY NETWORK** | | | | | | | | | | | | | | | | | | | |
| List name, relationship, and contact information for anyone the family identifies as being a support. This can include family, friends, and service providers. | | | | | | | | | | | | | | | | | | | |
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| **WORKER’S SCALING ASSESSMENT OF SUBSTANCE USE AND MENTAL HEALTH** | | | | | | | | | | | | | | | | | | | |
| Scaling: On a scale of 0 to 10 where 10 is parents’ substance use does not affect their ability to parent their infant and 0 they do not have the ability to parent their infant based on substance use. | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| Scaling: On a scale from 0 to 10, where 10 is parent’s mental health needs do not affect their ability to parent and 0 they do not have the ability to parent their children based on mental health needs. | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | |
| **OTHER OBSERVATIONS, CONCERNS, OR RECOMMENDATIONS** | | | | | | | | | | | | | | | | | | | |
| Use this section to comment and summarize any other observations, concerns, or recommendations that have not already been addressed above. | | | | | | | | | | | | | | | | | | | |
| **SIGNATURES** | | | | | | | | | | | | | | | | | | | |
| **CHILDREN’S SERVICE WORKER >** | | | | | |  | | | | | | | | | | | | DATE | |
| **SUPERVISOR>** | | | | | |  | | | | | | | | | | | | DATE | |