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| Missouri State Seal | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN’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 [ ]  NoComments: |
| **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       |