



VOLUNTARY SERVICE PLAN (VSP)

Mother _____ D.O.B. _____ Home Address: _____
Baby _____ D.O.B. _____ Mailing Address: _____
Male or Female _____ Phone #: _____
Homeless [] Yes [] No CAP-SLO Case Manager _____

I, _____, understand that I have been identified as using _____ during my pregnancy, as has been discussed with me. It has been explained to me, and I understand, that any use of drugs or alcohol, including use while breastfeeding or driving, can cause physical harm to my baby and me. My goal is to discontinue my use of drugs and/or alcohol for the benefit of my baby and me. I voluntarily agree to cooperate with the plan recommended below:

- 1. To go to Drug and Alcohol Services walk-in clinic for a drug and alcohol assessment within 2 weeks of today, and to cooperate with all treatment/services and recommendations.

San Luis Obispo Atascadero Grover Beach
2180 Johnson Ave 3556 El Camino Real 1523 Longbranch Ave.
805-781-4790 805-461-6158 805-473-7087
Mondays 9-11:30 or 2:30-5:30 Tuesdays 9-11:30 or 2:30-5:30 Mondays 9-11:30 or 2:30-5:30

- 2. To cooperate with treatment/service recommendations and ongoing assessments by the San Luis Obispo County Public Health Nurse, 2191 Johnson Ave., San Luis Obispo, CA 805-781-5500.
3. To make and keep all recommended medical appointments for my baby, and to follow the recommendations of my baby's pediatrician.

Doctor: _____ Phone#: _____

- 4. Other _____

I have read and understand this agreement and I authorize (name of hospital) _____ personnel to provide Child Welfare Services, Drug & Alcohol Services, Public Health and the pediatrician stated above my medical documents and my baby's medical documents which may include my prenatal chart, laboratory or other pertinent test results, as they pertain to addressing the need stated above so that these agencies may better assist me. I also authorize hospital personnel to receive reports from these agencies. I understand that a copy of this agreement and the VSP Needs Assessment will be sent to, or kept with, these stated agencies. If I do not follow through as I have agreed, these agencies will send a follow-up report to Child Welfare Services about my failure to comply.

Mother Date Witness

Send this form, along with a copy of the VSP Needs Assessment to:
Drug and Alcohol Services: Fax: 805-461-6114
Public Health: Fax: 805-781-1372
Child Welfare Services: Fax: 805-781-1803
Pediatrician