COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF SOCIAL SERVICES

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	