



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Office of Children, Youth & Families
Deputy Secretary's Office

JUL 19 2011

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Dear Colleague:

On December 9, 2002 Senate Bill 654, Printer's Number 2386 was signed into law as Act 201 of 2002 now known as the Newborn Protection Act. A copy of the Newborn Protection Act, which was sent to public children and youth social service agencies on July 21, 2003 allows a parent of a newborn, a child less than 28 days of age, to leave their child in the care of a hospital without being criminally liable providing that the following criteria are met:

- The parent expresses orally or through conduct that they intend for the hospital to accept the newborn; and
- The newborn is not a victim of child abuse or criminal conduct.

Pennsylvania's program for newborn protection has become known as the "Safe Haven Program of Pennsylvania". The Department also issued a letter explaining the requirements to hospitals, county agencies and law enforcement officials. Additionally, numerous fact sheets and public awareness materials were distributed.

The purpose of the attached OCYF Bulletin #3490-11-01 entitled "Implementation of Act 201 of 2002" is to reinforce the requirements of Act 201 of 2002, as well as to reinforce reporting requirements specific to hospitals and county children and youth agencies.

Safe Haven is a primary prevention program specifically intended to prevent newborn death due to unsafe abandonment. Many women who abandon their newborns are in their late teens or early 20's and have been hiding their pregnancies. By offering a safe and anonymous alternative it is hoped that women in these situations will take their newborns to the hospital instead of abandoning them.

Newborns that are relinquished at the hospital are placed into foster care through the county children and youth agency. Through the Safe Haven Program these children are placed directly into pre-adoptive homes. Adoption serves the best interest of these children as the parents have indicated through their actions that they wish to relinquish care and responsibility for them. Since the law was enacted, 14 children have benefited from this program.

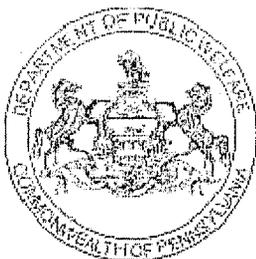
Thank you for your continued efforts to ensure that children are safe through the prevention of newborn abandonment.

Sincerely,

A handwritten signature in black ink that reads "Cathy A. Utz".

Cathy A. Utz
Acting Deputy Secretary

Attachments



OFFICE OF CHILDREN, YOUTH AND FAMILIES BULLETIN

COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC
WELFARE

NUMBER:

3490-11-01

ISSUE DATE:

July 15, 2011

EFFECTIVE DATE:

February 7, 2003

SUBJECT:

Implementation of Act 201 of 2002

BY:

Cathy A. Utz,

Acting Deputy Secretary for Children, Youth
and Families

SCOPE:

COUNTY CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
COUNTY CHILDREN AND YOUTH ADVISORY COMMITTEES
PRIVATE CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
COUNTY COMMISSIONERS
PENNSYLVANIA CHILDREN AND YOUTH ADMINISTRATORS ASSOCIATION
LAW ENFORCEMENT OFFICIALS
HOSPITALS
OTHER INTERESTED PARTIES

PURPOSE:

The purpose of this bulletin is to outline the requirements for Act 201 of 2002, the Newborn Protection Act, which amended Title 23, Pa.C.S., Chapter 63 (relating to the Child Protective Services Law) (CPSL), thereby creating Chapter 65. Pennsylvania's program for newborn protection has become known as the "Safe Haven Program of Pennsylvania." The purpose of Safe Haven Program is to protect newborns who might otherwise be abandoned or harmed by permitting a parent to leave a newborn at a hospital without fear of criminal prosecution when the newborn has not been a victim of suspected child abuse or another crime.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Regional Directors

Origin: Carrie Keiser, OCYF, P.O. Box 2675, Harrisburg, PA 17105-2675, (717) 705-4401,
ckeiser@state.pa.us

BACKGROUND:

On December 9, 2002, Governor Edward G. Rendell signed Senate Bill 654, Printer's Number 2386 into law as Act 201 of 2002 now known as the Newborn Protection Act. The Newborn Protection Act allows a parent of a newborn, a child less than 28 days of age, to leave their child in the care of a hospital without being criminally liable providing that the following criteria are met:

- The parent expresses orally or through conduct that they intend for the hospital to accept the newborn; and
- The newborn is not a victim of child abuse or criminal conduct.

Safe Haven is a primary prevention program specifically intended to prevent newborn death due to unsafe abandonment. Many women who abandon their newborns are in their late teens or early 20's and have been hiding their pregnancies. By offering a safe and anonymous alternative it is hoped that women in these situations will take their newborns to the hospital instead of abandoning them.

Newborns who are relinquished at the hospital are placed into foster care through the county agency. Through the Safe Haven Program these children are placed directly into pre-adoptive homes. Adoption serves the best interest of these children as the parents have indicated through their actions that they wish to relinquish care and responsibility for these children.

Consistent with Title 42, CFR, Subpart C, §435.210 (a)(4) (relating to individuals included in optional groups) and the Office of Income Maintenance, Supplemental Handbook, Foster Care and Adoption Assistance, §850.21, Automatic Enrollment, the newborn is immediately eligible for Medicaid when taken into protective custody.

A copy of the Newborn Protection Act was sent to public children and youth social service agencies on July 21, 2003. The Department also issued a letter explaining the requirements to hospitals, county agencies and law enforcement officials. Additionally, numerous fact sheets and public awareness materials were distributed.

DEFINITIONS:

Child abuse – The term "child abuse" shall mean any of the following:

- (i) Any recent act or failure to act by a perpetrator which causes nonaccidental serious physical injury to a child under 18 years of age.
- (ii) Any act or failure to act by a perpetrator which causes nonaccidental serious mental injury to or sexual abuse or sexual exploitation of a child under 18 years of age.
- (iii) Any recent act, failure to act or series of such acts or failures to act by a perpetrator which creates an imminent risk of serious physical injury to or sexual abuse or sexual exploitation of a child under 18 years of age.
- (iv) Serious physical neglect by a perpetrator constituting prolonged or repeated lack of supervision or the failure to provide essentials of life,

including adequate medical care, which endangers a child's life or development or impairs the child's functioning.

County agency or agency – The county children and youth social services agency established pursuant to section 405 of the act of June 24, 1937 (P.L. 2017, No. 396), known as the County Institution District Law, or its successor, and supervised by the Department of Public Welfare under Article IX of the act of June 13, 1967 (P.L. 31, No. 21), known as the Public Welfare Code.

Department - The Department of Public Welfare of the Commonwealth.

Health care provider – A person who is licensed or certified by the laws of this Commonwealth to administer health care in the ordinary course of business or practice of a profession. For purposes of accepting a newborn as provided in §6504 (a)(1) (relating to accepting newborns) and for immunity provided pursuant to §6507 (relating to immunity granted to health care providers and hospitals), both sections found in the Newborn Protection Act, the term includes administrative, managerial and security personnel and any other person employed by a hospital.

Hospital - An institution having an organized medical staff which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services for the care or rehabilitation of people who are injured, disabled, pregnant, diseased, sick or mentally ill. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for people with mental illness or those facilities primarily engaged in providing rehabilitation services or long-term care.

Newborn - A child less than 28 days of age as reasonably determined by a physician.

DISCUSSION:

When a newborn is relinquished at a hospital it requires a coordinated effort at the local level as there are multiple community partners involved. Coordination between the hospital, county agency, law enforcement officials and DPW is required.

Hospital Responsibilities:

The hospital must ensure staff is familiar with the Newborn Protection Act and distribute materials provided by the Department. The hospital must also adopt a written policy in accordance with the provisions of the Newborn Protection Act. There should be signs posted within the hospital indicating that the individual relinquishing the newborn should wait until the newborn is received by staff. If the individual relinquishing the newborn is unwilling or unable to wait, they should be directed, by the signs, where to place the newborn and how to alert staff to the newborn. Hospital protocol should take the information below into consideration as well as the procedures outlined in the sample protocol (See Attachment A).

When a newborn is brought to the hospital, a physician, the director, or a person specifically designated by the director of a hospital, is required to take a newborn into

protective custody as provided in §6315 (a)(3) (relating to taking child into protective custody) of the CPSL. The hospital is also required to take protective custody of a newborn if the child is born in the hospital and the parent expresses orally or through conduct that they intend for the hospital to accept the newborn. All identifying information of birth parent obtained by the hospital should be given to the local county agency. As long as the child is less than 28 days old, as reasonably determined by a physician, they are considered a Safe Haven child.

Pennsylvania established the Pennsylvania Adoption Information Registry (PAIR) as a means for parents who gave birth in Pennsylvania and placed their child for adoption to voluntarily file family medical and social history information. The hospital should give the parent the opportunity to provide birth family information, according to §6504 (b) (relating to accepting newborns). Family medical and social history information can help to identify future medical risks to the adoptee. Hospitals are encouraged to utilize the forms provided by PAIR to receive parent medical and social history information. Birth parents may submit this information by completing the *Birth Parent Authorization to Release Information and Registration Form* (See Attachment B). PAIR only shares medical and social history information upon the adopted child's request. The PAIR Birth Parent Authorization to Release Information and Registration Form can found online at <http://www.adoptpakids.org/Forms.aspx>. Completed forms should be mailed to the following address:

Pennsylvania Adoption Information Registry
P.O. Box 4379
Harrisburg, Pennsylvania 17111-0379
1-800-227-0225

The hospital is required to perform a medical evaluation of the newborn and any act necessary to care for and protect the physical health and safety of the child as stated in §6504 (a)(2) (relating to accepting newborns). Resuscitation as required will be initiated.

When a newborn is received by a hospital the hospital is required to notify the local county agency and law enforcement agency immediately by telephone. Within 48 hours of providing an oral report to the local county agency and law enforcement agency, the hospital must file a written report, the Relinquished Newborn Report Form for Hospitals (See Attachment C). This should be completed by doing the following:

One copy of the Relinquished Newborn Report Form for Hospitals must be submitted to:

- Local county agency who receives custody of the newborn;
- Local municipal police department or the Pennsylvania State Police where no municipal police jurisdiction exists; and
- Pennsylvania Department of Public Welfare, Office of Children, Youth and Families.

Hospital Immunity and Penalties

No hospital nor health care provider at a hospital shall be subject to civil liability or criminal penalty solely by reason of complying with §6507 (relating to immunity granted to health care providers and hospitals), except for failure to report acceptance in accordance with §6506 (relating to failure to report acceptance of newborns). Consequences of failing to report acceptance include a summary offense for the first intentional or knowingly failure to report and a misdemeanor of the third degree for the second or subsequent failure to report.

County Agency's Responsibilities:

When a hospital takes protective custody of a newborn pursuant to the Newborn Protection Act, the hospital is required to contact the local county agency and law enforcement officials (LEO) immediately by telephone. The local county agency is then required to file a petition to take custody of the newborn and place the newborn in a pre-adoptive home.

A written report, Relinquished Newborn Report Form for Hospitals (See Attachment C) should have been submitted within 48 hours by the hospital taking protective custody of the newborn to the local county agency. The county agency then must submit a written report, the Relinquished Newborn Report Form for the County Children and Youth Agency, (See Attachment D) within 72 hours of assuming custody of the newborn, to the Department's, Office of Children, Youth and Families. The county agency must also submit an updated Relinquished Newborn Report Form anytime new information becomes available.

In addition to what the county agency would normally do when notified by a hospital that a child has been taken into protective custody, the Newborn Protection Act also requires the county agency to do the following:

- Make diligent efforts within 24 hours to identify the newborn's parent, guardian, custodian or other family members and their whereabouts;
- Request LEO to utilize resources associated with the National Crime Information Center (NCIC);
- Assume responsibility for making decisions regarding the newborn's medical care, unless otherwise provided by court order (Title 23 Pa.C.S. §6316) (relating to admission to private and public hospitals) of the CPSL;
- Provide outreach and counseling services to prevent newborn abandonment; and
- Continue the prevention of newborn abandonment publicity and education program.

The newborn is immediately eligible for Medicaid (refer to page 2, Background Section). It is the county agency's responsibility to complete the Medicaid process. The county should follow the Medicaid instructions provided on Attachment E.

The county agency shall follow the same procedures for any abandoned child the agency takes custody of such as filing for the birth certificate and the social security number.

While the intent of the Newborn Protection Act is to offer a safe and anonymous alternative to birth parents to keep newborns safe as opposed to abandoning them, if any identifying information of the birth parent is obtained, the county agency should follow protocol in terms of diligent search and termination of parental rights.

County children and youth agencies do not need to wait six months to file for termination of parental rights for an abandoned child based on aggravated circumstances as outlined in the Juvenile Act (Title 42, Pa.C.S. Chapter 63), §6302 (1)(i), (relating to aggravated circumstances), which allows for a termination of parental rights to be filed if, *the child is in the custody of a county agency and either: the identity or whereabouts of the parents is unknown and cannot be ascertained and the parent does not claim the child within three months of the date the child was taken into custody.*

Grounds for filing a petition are also outlined in the Adoption Act (Title 23, Pa.C.S. Chapter 25), §2511 (a)(4), (relating to grounds for involuntary termination), which allows for termination of parental rights to be filed if, *the child is in the custody of an agency, having been found under such circumstances that the identity or whereabouts of the parent is unknown and cannot be ascertained by diligent search and the parent does not claim the child within three months after the child is found.*

Law Enforcement Officials Responsibilities:

LEO are required to assist the county agency in assuring the newborn is not a victim of child abuse or other criminal conduct by utilizing resources associated with the NCIC. LEO should assist the county agency in making diligent efforts to notify the newborn's parents, guardian, custodian or other family member regarding the child's whereabouts.

Department of Public Welfare Responsibilities:

The Department is responsible to order immediate admittance, treatment and care if a hospital fails to admit and properly care for a child. This shall be enforceable by civil action. A child, through an attorney, may also seek independent civil action for damages. The Department expects coordination between all partners on the local level and if there are issues identified, the Department has the authority and responsibility to intervene.

The Department is responsible for continued prevention of newborn abandonment through publicity and education programs. Education materials for use by hospitals and health care providers are provided by the Department. Hospitals and county children and youth agencies may find the Safe Haven Fact Sheet for Hospitals (Attachment F) and Safe Haven Fact Sheet for County Children and Youth Agency's (Attachment G) helpful in educating staff. Each fact sheet outlines the responsibility of

the hospital and county agency under the Newborn Protection Act and may serve as a quick reference guide.

In March 2004, the Department instituted a toll-free Safe Haven Helpline, 1-866-921-SAFE (7233), to call for information about Safe Haven. The helpline can be accessed 24 hours a day, seven days a week. Women in crisis and individuals seeking information may speak with a person regarding the program and find out the location of the nearest hospital. Callers are also provided with the Healthy Baby Helpline, 1-800-986-BABY (2229), to call for information on free or low cost health care services.

In November 2006, the Department launched a new Safe Haven Web site, www.secretssafe.org, which is tailored to expectant mothers. They, as well as agencies, hospitals, etc. may download all educational materials related to the program.

The Department must also report annually on the number and disposition of newborns accepted under the Newborn Protection Act in the Annual Child Abuse Report.

The written report forms, Relinquished Newborn Report Form for Hospitals (Attachment C) and Relinquished Newborn Report Form for the County Children and Youth Agency (Attachment D) can be downloaded from the Department's web site at www.dpw.state.pa.us under Safe Haven.

Attachments

Attachment A – Sample Hospital Protocol for Safe Haven

Attachment B – Birth Parent Authorization to Release Information and Registration Form

Attachment C – Relinquished Newborn Report Form for Hospitals

Attachment D – Relinquished Newborn Report Form for County Children and Youth Agency

Attachment E – Medicaid Process

Attachment F – Safe Haven Fact Sheet for Hospitals

Attachment G – Safe Haven Fact Sheet for County Children and Youth Agency

Sample Hospital Protocol for Safe Haven

Purpose: To define the process and procedure for the reception of newborns (less than 28 days old) in accordance with the Newborn Protection Act (Act 201 of 2002). The purpose of this Act is to protect newborns who might otherwise be abandoned or harmed by permitting a parent to leave a newborn at a hospital without fear of criminal prosecution when the child has not been a victim of suspected child abuse or other crime.

Procedure:

1. Signs will indicate that the individual relinquishing the newborn should wait until the baby is received by staff. If the person is unwilling or unable to wait, they will be directed, by the signs where to place the baby and how to alert staff to the baby.
2. Any hospital staff encountering the individual presenting a newborn will ask only the following questions:
 - a. Is there any family medical history we need to know?
 - b. Were there any problems you observed during birth?
 - c. Do you need any care for yourself?
 - d. Staff may share "We will take good care of this baby" if they feel the need to say something.
3. If the mother needs medical attention, she should be registered as "Jane Doe."
4. The individual presenting the newborn will be given the Safe Haven Medical Questionnaire and gently encouraged to complete the form. The individual will be given the option of filling out the questionnaire at the hospital, or taking the form with them and returning the self-stamped questionnaire via mail.
5. The hospital staff receiving the newborn will take the baby to the treatment area of the Emergency Department. If the hospital staff is a non-licensed employee, the individual will approach the first registered nurse or physician encountered and transfer the baby to that person. Any medical information obtained from the individual who brought the newborn will be relayed to the registered nurse or physician.
6. Resuscitation as required will be initiated. The in-house attending pediatrician on-call will then be notified. The pediatrician will consult via telephone or present to the Emergency Department to assess the infant and assume care.
7. An Emergency Department chart will be generated for each newborn.
8. The newborn is immediately eligible for Medicaid.
9. The Emergency Department Charge Nurse will contact the county children and youth agency and the local police immediately by telephone.
10. Within 48 hours of providing an oral report to the local county agency and law enforcement agency, the Emergency Department Charge Nurse, must file a written

report, The Relinquished Newborn Report Form for Hospitals. One copy of the Relinquished Newborn Report Form for Hospitals must be submitted to:

- a. Local county agency who receives custody of the newborn;
- b. Local municipal police department or the Pennsylvania State Police where no municipal police jurisdiction exists; and
- c. Pennsylvania Department of Public Welfare, Office of Children, Youth and Families.



pennsylvania
DEPARTMENT OF PUBLIC WELFARE
www.dpw.state.pa.us

**Pennsylvania Adoption Information Registry
Birth Parent Authorization to Release Information
and Registration Form**

P.O. Box 4379, Harrisburg, PA 17111-0379 | 1.800.227.0225

Completing this form is voluntary. However, we encourage you to provide as much information as you can. You may choose to:

1. release information that will identify you to your birth child or their family;
2. provide only non-identifying information that will not identify you; or
3. both.

Each section of this form is designated as identifying or non-identifying. Please type or print in black or blue ink. Each birth parent who reports information must complete a separate form for each child placed for adoption. If you don't know or are unsure about an answer, leave it blank.

Identifying information will include names and contact information.

Non-identifying information does not include names and contact information but does include medical, social and educational information, etc.

Please check the appropriate choice below:

- I am providing family information for the first time. I am updating family information previously submitted.

Please indicate your relationship to the child for whom you are completing this information:

- Birth Mother Birth Father

I. CHILD'S INFORMATION

CHILD'S CURRENT NAME (Last, First, Middle)		CHILD'S NAME RECORDED ON ORIGINAL BIRTH CERTIFICATE (Last, First, Middle)		
DATE OF BIRTH (MM/DD/YYYY)		GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PLACE OF BIRTH	COUNTY	CITY/MUNICIPALITY	STATE	HOSPITAL (if applicable)
LOCATION WHERE PARENTAL RIGHTS WERE TERMINATED (City/County, State)		DATE PARENTAL RIGHTS WERE TERMINATED (MM/DD/YYYY)		

AUTHORIZATION TO RELEASE IDENTIFYING INFORMATION

You may select as many or as few of the choices listed below as you wish. I agree to release identifying information to the individuals checked below:

- | | |
|---|--|
| <input type="checkbox"/> My birth child (when he or she turns 18) | <input type="checkbox"/> My birth child's descendants (when my birth child is deceased) |
| <input type="checkbox"/> My birth child's adoptive parents (if my birth child is under 18 or adjudicated incapacitated) | <input type="checkbox"/> My birth child's birth grandparents provided my birth child is at least 21 or I am adjudicated incapacitated or deceased. |
| <input type="checkbox"/> My birth child's legal guardian | <input type="checkbox"/> My birth child's birth siblings if both are 21. |

Even if you choose to release identifying information to your birth child, you may specify that you do or do not wish contact.

- I wish to have contact with my birth child. I do not wish to have contact with my birth child.

I understand that by my signature below, I am agreeing to the release of identifying information to the people checked above. I may change this consent at any time by updating this form or by submitting a Withdrawal of Authorization to Release Information Form.

SIGNATURE OF BIRTH PARENT		DATE	
---------------------------	--	------	--



REGISTRATION INFORMATION

II. BIRTH MOTHER'S PERSONAL (IDENTIFYING) INFORMATION				
BIRTH MOTHER'S NAME (Last, First Middle)		PREVIOUS NAMES (Include maiden name, nicknames, and aliases: Last, First, Middle)		
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE		
STREET ADDRESS		CITY	STATE	ZIP CODE
BIRTH MOTHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)				
HIGHEST GRADE LEVEL ACHIEVED	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
I WOULD DESCRIBE MYSELF AS:	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
MARITAL STATUS	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
CHILDREN	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	
RACE/ETHNICITY (Check all that apply)				
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White	<input type="checkbox"/> Other _____	Ethnicity Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	HAIR TYPE
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight
COMPLEXION			HANDEDNESS	
<input type="checkbox"/> Light	<input type="checkbox"/> Olive	<input type="checkbox"/> Medium	<input type="checkbox"/> Dark	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed
BIRTH MOTHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed				
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE			FATHER'S NAME	



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III. BIRTH FATHER'S PERSONAL (IDENTIFYING) INFORMATION

BIRTH FATHER'S NAME (Last, First Middle)		PREVIOUS NAMES (Include nicknames and aliases. Last, First, Middle)	
DATE OF BIRTH (MM/DD/YYYY)		(AREA CODE) DAYTIME TELEPHONE	
STREET ADDRESS		CITY	STATE ZIP CODE

BIRTH FATHER'S BACKGROUND INFORMATION (NON-IDENTIFYING)

HIGHEST GRADE LEVEL ACHIEVED	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College	<input type="checkbox"/> Graduate Degree
I WOULD DESCRIBE MYSELF AS:	<input type="checkbox"/> Lower Income	<input type="checkbox"/> Middle Income	<input type="checkbox"/> Upper Income	
MARITAL STATUS	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
CHILDREN	<input type="checkbox"/> Boy # _____		<input type="checkbox"/> Girl # _____	

RACE/ETHNICITY (Check all that apply)

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Native Hawaiian/Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Other _____	Ethnicity Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	HAIR TYPE
				<input type="checkbox"/> Curly <input type="checkbox"/> Straight

COMPLEXION	HANDEDNESS
<input type="checkbox"/> Light <input type="checkbox"/> Olive <input type="checkbox"/> Medium <input type="checkbox"/> Dark	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed

BIRTH FATHER'S OTHER CHILDREN - (IDENTIFYING) Use Additional Page if Needed

PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		
PLACED FOR ADOPTION <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
CITY, STATE	MOTHER'S NAME		



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IV. PREGNANCY, BIRTH AND EARLY CHILDHOOD HISTORY (BIRTH MOTHER ONLY - NON-IDENTIFYING)

AGE AT FIRST MENSTRUAL PERIOD	IF APPLICABLE, AGE AT MENOPAUSE	NUMBER OF PREGNANCIES

NUMBER OF LIVE BIRTHS	NUMBER OF MISCARRIAGES	MULTIPLE BIRTHS
		<input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other: _____

HISTORY OF REPRODUCTIVE SYSTEM PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)	
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Fibroid Tumors (Benign)
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian Cysts (Benign)	
<input type="checkbox"/> Other: _____		

THE QUESTIONS BELOW PERTAIN SPECIFICALLY TO THE PREGNANCY FOR THE CHILD IDENTIFIED IN SECTION I.

COMPLICATIONS DURING THIS PREGNANCY	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, check all that apply below)	
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Toxemia	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Other: _____	

ANY INJURY DURING PREGNANCY? YES NO (If YES, describe below)

X-RAY PROCEDURES DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Month of Pregnancy _____)	
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If YES, purpose of X-Ray: _____

DISEASES DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list below)	
-----------------------------------	---	--

DISEASE	TREATMENT

LENGTH OF PREGNANCY?	<input type="checkbox"/> Premature - Number of weeks early: _____ <input type="checkbox"/> Full-Term <input type="checkbox"/> Post-Term - Number of weeks late: _____	
-----------------------------	---	--

TOBACCO USE DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of cigarettes daily: _____)	
--------------------------------------	---	--

ALCOHOL USE DURING PREGNANCY?	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, Average number of drinks weekly: _____)	
--------------------------------------	--	--

LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY

DURATION OF LABOR	Hours: _____	TYPE OF DELIVERY	<input type="checkbox"/> Spontaneous	<input type="checkbox"/> Breech	<input type="checkbox"/> Breech	<input type="checkbox"/> Caesarean
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COMPLICATIONS DURING DELIVERY?	<input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, describe below)	
---------------------------------------	---	--



V. FAMILY MEDICAL HISTORY (NON-IDENTIFYING)

This section applies only to the birth family member who is completing this form and his or her blood relatives.

- Check SELF if medical condition applies to the BIRTH PARENT who is completing the form.
- Check FAMILY if medical condition applies to a blood relative of the birth parent.
 - When FAMILY is checked, complete the RELATIONSHIP TO BIRTH PARENT column.
 - Indicate if family member is a maternal (birth parent's mother's side) or a paternal (birth parent's father's side) relative.

MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO ADOPTEE	MEDICAL CONDITION (check all that apply)	SELF	FAMILY	RELATIONSHIP TO ADOPTEE
ALLERGIES							
ENVIRONMENTAL				FOOD			
PLANT				DRUG/CHEMICAL			
ANIMAL							
OTHER (specify):							
EAR & EYE CONDITIONS							
CATARACTS				FAR-SIGHTED			
GLAUCOMA				ASTIGMATISM			
COLOR BLINDNESS							
BLINDNESS	Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			Type: <input type="checkbox"/> Partial <input type="checkbox"/> Total			
DEAFNESS	Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			Type: <input type="checkbox"/> Partial <input type="checkbox"/> Total			
OTHER (specify):							
BLOOD, HEART & CIRCULATORY CONDITIONS							
HEART ATTACK				HIGH BLOOD PRESSURE			
STROKE				ANEMIA			
HARDENING OF THE ARTERIES				HEMOPHILIA			
BLOOD CLOTS IN THE LEGS				SICKLE CELL ANEMIA			
OTHER (specify):							
BRAIN & NERVOUS SYSTEM CONDITIONS							
ALZHEIMER'S DISEASE				PARKINSON'S DISEASE			
MULTIPLE SCLEROSIS				MIGRAINE HEADACHES			
EPILEPSY & OTHER SEIZURE OR CONVULSIVE CONDITIONS				HUNTINGTON'S DISEASE			
CEREBRAL PALSY				TOURETTE'S SYNDROME			
OTHER (specify):							



MEDICAL CONDITION (check all that apply)	SELF FAMILY	RELATIONSHIP TO ADOPTEE	MEDICAL CONDITION (check all that apply)	SELF FAMILY	RELATIONSHIP TO ADOPTEE
HORMONAL DISORDERS					
DIABETES					
THYROID DISORDER		Specify: <input type="checkbox"/> Overactive thyroid <input type="checkbox"/> Underactive thyroid <input type="checkbox"/> Goiter <input type="checkbox"/> Iodine Deficiency			
PITUITARY GLAND DISORDER		Specify: <input type="checkbox"/> Excessive hormone <input type="checkbox"/> Reduced hormone <input type="checkbox"/> Growth hormone deficiency			
OTHER (specify):					
INTELLECTUAL & DEVELOPMENTAL CONDITIONS					
DOWN SYNDROME					
PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM					
MENTAL RETARDATION		Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
SPEECH/COMMUNICATION DISORDERS		Cause: <input type="checkbox"/> Brain damage <input type="checkbox"/> Developmental delay <input type="checkbox"/> Structural abnormality (mouth)			
LEARNING DISORDERS		Specify: <input type="checkbox"/> Dyslexia (reading) <input type="checkbox"/> Dysgraphia (writing) <input type="checkbox"/> Minimal brain damage			
OTHER (specify):					
MENTAL & BEHAVIORAL CONDITIONS					
SCHIZOPHRENIA			ATTENTION DEFICIT DISORDER (ADD)		
ANXIETY DISORDER			ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)		
MAJOR DEPRESSIVE DISORDER			DRUG ABUSE		
BIPOLAR DISORDER (MANIC DEPRESSIVE)			POST-TRAUMATIC STRESS DISORDER		
ALCOHOLISM			ANOREXIA NERVOSA		
OBSESSIVE COMPULSIVE DISORDER					
OTHER (specify):					
GASTROINTESTINAL URINARY SYSTEM CONDITIONS					
KIDNEY DISEASE		Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
LIVER DYSFUNCTION		Cause: <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
GALL BLADDER DISORDER		<input type="checkbox"/> Gall stones <input type="checkbox"/> Infection <input type="checkbox"/> Tumor			
ULCERS					
DIVERTICULITIS					
ULCERATIVE COLITIS/CROHN'S DISEASE					
OTHER (specify):					



**Pennsylvania Adoption Information Registry
Birth Parent Authorization to Release Information
and Registration Form**

P.O. Box 4379, Harrisburg, PA 17111-0379 | 1.800.227.0225

MEDICAL CONDITION (check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO ADOPTEE	MEDICAL CONDITION (check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO ADOPTEE
CANCER							
BLOOD (Leukemia)				BRAIN			
COLON				HODGKIN'S DISEASE			
PROSTATE				PANCREAS			
UTERINE				LIVER			
BREAST				OVARIAN			
LUNG				CERVICAL			
SKIN				STOMACH			
BONE				THROAT			
OTHER (specify):							
GENETIC CONDITIONS							
MUSCULAR DYSTROPHY				MARFAN'S SYNDROME			
SPINA BIFIDA				TAY-SACHS DISEASE			
CLUB FOOT				HARE LIP			
DWARFISM				CLEFT PALATE			
CYSTIC FIBROSIS							
OTHER (specify):							
OTHER CONDITIONS							
HIGH CHOLESTEROL				OBESITY			
ARTHRITIS				LUPUS			
ASTHMA							
EXPOSURE TO CHEMICALS & TOXIC MATERIALS (specify):							
OTHER (specify):							

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (section 9404 of the Pennsylvania Crimes Code). Further, I understand that it is my responsibility to notify the registry of any change in my address or submitted information.

SIGNATURE		DATE	
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pennsylvania
DEPARTMENT OF PUBLIC WELFARE

www.dpw.state.pa.us

SAFE HAVEN REPORT
Relinquished Newborn Report Form

Hospital

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE FILLING OUT THIS FORM

INSTRUCTIONS:

- The hospital is required to notify the local county children and youth agency and the local municipal police department, or the Pennsylvania State Police when no municipal police jurisdiction exists, immediately by telephone when a newborn is received.
- It is recommended this report form be completed by the hospital staff member who has first contact with the newborn or per the hospital's Safe Haven policy or protocol.
- Type or print in blue or black ink.
- If you do not know or are unsure about an answer, write "unknown" in the space provided.
- Within 48 hours of providing the oral report to the local county agency and law enforcement agency, one copy of the report form must be forwarded to:
 - The local county children and youth agency with custody;
 - The local municipal Police Department or the Pennsylvania State Police where no municipal police jurisdiction exists; and
 - The Pennsylvania Department of Public Welfare, Office of Children, Youth and Families, P.O. Box 2675, Harrisburg, PA 17105-2675, Attention: Safe Haven.

Date newborn brought to hospital:	Name, address and phone number of hospital:
Time of incident:	County where hospital is located:
Name of newborn:	
Sex of newborn:	
Race of newborn:	
Actual or estimated date of birth of newborn:	
Was the newborn a victim of abuse/neglect or an other crime?	
Name and relationship of person who brought the newborn to the hospital. If name and relationship are unknown, please provide description of the individuals who brought the newborn to the hospital:	
Report made to county children and youth agency (date, time and person spoken to):	
Report to law enforcement officials (name of law enforcement agency, date time and person spoken to):	
Medical tests performed:	
Health concerns/problems:	
Name, title and direct phone number of person who initially received the newborn:	
Name, title and direct phone number of person completing this form (if different from above):	



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

www.dpw.state.pa.us

SAFE HAVEN REPORT
Relinquished Newborn Report Form

County Children and Youth Agency

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE FILLING OUT THIS FORM

INSTRUCTIONS:

- Please check if new registration or update.
- An update should be submitted anytime new information becomes available.
- The county staff member who has first contact with the newborn should complete this form.
- Type or print in blue or black ink.
- If you do not know or are unsure about an answer, write "unknown" in the space provided.
- Within 72 hours of assuming custody of the newborn, submit one copy of completed report form to the Department of Public Welfare, Office of Children, Youth and Families, P.O. Box 2675, Harrisburg, PA 17105-2675, Attention: Safe Haven.

<input type="checkbox"/>	New Registration
<input type="checkbox"/>	Update

County children and youth agency information (name, address and phone number):	Date county children and youth received custody of newborn:
	Name of individual who received custody of newborn:
Time county children and youth received newborn:	County:

Name of newborn:				
Sex of newborn:				
Race of newborn:				
Actual or estimated date of birth of newborn:				
Was the newborn a victim of abuse/neglect or an other crime?				
Were parents or relatives located? If yes, please complete the following for mother, father or relative:	Birth mother name:	Social Security number:	Address:	Phone number:
	Birth father name:	Social Security number:	Address:	Phone number:
	Relative name:	Relationship to newborn:	Address:	Phone number:
Parents' birth date, race, education, marital status:	Birth mother DOB:	Race:	Education:	Marital status:
	Birth father DOB:	Race:	Education:	Marital status:
Newborn's current court disposition:				
Permanency goal:				
Date permanency achieved:				
Name, title and direct phone number of county children and youth staff who initially received the newborn:				
Name, title and direct phone number of staff member completing this form:				
Name, title and direct phone number of assigned county agency caseworker (if different from above):				
Name, title and direct phone number of the assigned county caseworker's supervisor:				

SAFE HAVEN Medicaid Process

Act 201 of 2002 known as the Newborn Protection Act allows a parent of a newborn, a child less than 28 days of age, to leave their child in the care of a hospital without being criminally liable providing that the following criteria are met:

- The parent expresses orally or through conduct that they intend for the hospital to accept the newborn; and
- The newborn is not a victim of child abuse or criminal conduct.

Instructions:

- ❖ The county children and youth agency is required to follow this process when registering a newborn, relinquished at a hospital under the Newborn Protection Act, for Medicaid with their local County Assistance Office (CAO).
- ❖ The county children and youth agency will be responsible for determining all the required information on the CY-60 form, *Auto Enrollment in Medical Assistance for Children in Placement (see attached)*.
- ❖ Via telephone, fax or e-mail, the county children and youth agency will provide the CAO with the newborn's name, birth date, sex, citizenship, race and ethnicity. This will be provided to the CAO within 24 hours of notification of the newborn. If notification occurs on a weekend or holiday, the children and youth agency will provide the information to the CAO on the next work day. The CY-60 form will be sent within 48 hours of notification of the newborn.
- ❖ The county children and youth agency will provide the hospital billing department with the child's name and birth date immediately.
- ❖ The county children and youth agency will provide the Medicaid number to the hospital billing department when it is known.

Registration Process:

When completing the CY-60 in the following areas answer accordingly.

- ❖ **Birth Date:** If unknown, the newborn's birth date will be reasonably determined by the physician. If the physician is unable to make a reasonable determination, the date the newborn is relinquished at the hospital will be used for the birth date.

❖ **Name:** The newborn's last name will be "Safehaven." The newborn's first name will be the first nine letters of the county name, followed by sequential lettering starting with "a." For example, Philadelphia's first newborn would be named (last name first), "Safehaven, Philadelpa." The second newborn in Philadelphia would be named "Safehaven, Philadelpb."

- When the alphabet has exhausted, begin with double lettering. For example--"aa", "ab", "ac", "ad."

❖ **Other information that is required:**

- Sex - identify whether the child is male or female;
- Citizen- the assumption will be yes unless there is verifiable information to the contrary;
- Race- best reasonable determination; and
- Ethnicity – best reasonable determination.

Case #
CCYA/JPO:
CAO:

CCYA/JPO REQUEST FOR CAO ACTION
 CCYA/JPO FILL OUT FORM WITH AS MUCH INFORMATION AS AVAILABLE AND FORWARD TO CAO WITHIN 5 DAYS
 OF CHILD'S INITIAL PLACEMENT or A CHANGE IN CHILD INFORMATION
 (SEE BACK OF FORM FOR CODE INFORMATION)

I. ACTION REQUESTED (COMPLETED BY CCYA/JPO) - CHECK ALL THAT APPLY

Automatic Enrollment in Medicaid
 Notification of Change or Additional Information
 Medicaid Non-IV-E Redetermination - TPL form attached
 Notification of "Age Out"
 Notification of Change in Placement/Discharge
 Subsidized Permanent Legal Custodianship Release

II. IDENTIFYING INFORMATION (COMPLETED BY CCYA/JPO)

1. Child's Name (Last, First, MI): _____ 2. Race: _____ 3. Social Security Number: _____ 4. Date of Birth: ____/____/____

5. Sex: Male Female
 6. Does CCYA/JPO Have an Access Card for the Child: Yes No Unknown
 7. Access Card and Issue #: _____ 8. Does the Child have Any Personal Income: Yes No Unknown

9. Specify Monthly Gross Income and Type: _____

III. PLACEMENT/REMOVAL INFORMATION (COMPLETED BY CCYA/JPO)

A. NOTICE OF CHILD'S INITIAL REMOVAL:
 1. Date of Initial Removal (Constructive): ____/____/____
 2. Date of Initial Placement: ____/____/____
 3. Relative/Caretaker from whom Child was Removed: _____

RELATIVE/CARETAKER NAME (LAST, FIRST, MI) AND ADDRESS:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO CHILD:

B. CHILD IS IN SUBSTITUTE CARE PLACEMENT:
 1. Substitute Care Provider:

NAME OF SUBSTITUTE CARE PROVIDER:	ADDRESS:

2. Effective Date: ____/____/____
 3. County Code where Placed:
 4. Placement Facility Code:

C. CHILD IS NO LONGER IN SUBSTITUTE CARE PLACEMENT:
 1. Name, Address and Relationship of the Caretaker to whom Child was Returned:

RELATIVE/CARETAKER NAME (LAST, FIRST, MI) AND ADDRESS:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO CHILD:

2. Effective Date: ____/____/____
 3. County Code where Child Returned:

D. CCYA/JPO INFORMATION AND AUTHORIZATION:

NAME: (PLEASE PRINT)	SIGNATURE:	DATE:	PHONE:

IV. CAO - COMPLETED BY CAO

A. INITIAL ACTION:

1. Child is from a Household that Receives: TANF
 Food Stamps
 Medicaid
 No Income Maintenance Benefits

2. Child Receiving SSI: No Yes
 Monthly Amount: _____

3. Automatic Medicaid Enrollment Authorization:
 Recipient # (10 Digit): _____
 Card Issue # (Two Digit): _____

4. Child is Currently Enrolled in HEALTHCHOICES and/or has Private Insurance: No Yes
 Name of Insurance: _____
 Policy #: _____

B. MEDICAID REDETERMINATION NON-IV-E CHILDREN:
 Child is Medicaid Eligible: Redet. Date: ____/____/____
 Child is Not Medicaid Eligible: Reason: _____

C. CONFIRM ADDITIONAL INFORMATION/UPDATES OR CHANGES ON CIS RECORD:
 County where Placed: _____
 Facility Placement Code: _____
 Other: _____

D. CAO INFORMATION/AUTHORIZATION:

NAME: (PLEASE PRINT)	SIGNATURE:	DATE:	PHONE:

CODES:

- 02 - SUBSTITUTE CARE PLACEMENT FROM COUNTY TO COUNTY WITHIN A MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE.
- 03 - SUBSTITUTE CARE PLACEMENT - COUNTY NOT IN MANDATORY MANAGED CARE.
- 04 - C&H/JPO PLACEMENT BH NE ZONE - THIS IS A PLACEMENT FOR CHILDREN IN SUBSTITUTE CARE (CSC) WHO RESIDE IN THE BH NE HEALTHCHOICES (HC) ZONE. IT IS USED WHEN A CHILD IS PLACED IN A COUNTY WITHIN THE SAME NE ZONE AS THE CHILD'S COUNTY OF RECORD. THIS CODE IS NOT TO BE USED FOR BH-MCO OR MEDICAID FEE-FOR-SERVICE APPROVED RTF PLACEMENTS.
- 05 - C&Y/JPO PLACEMENT (OTHER THAN CODE 04) - THIS CODE IS TO BE USED WHEN A CHILD FROM THE BH NE ZONE IS PLACED IN SUBSTITUTE CARE THAT DOES NOT MEET THE 04 CRITERIA DESCRIBED ABOVE. THIS CODE IS NOT TO BE USED FOR BH-MCO OR MEDICAID FEE-FOR-SERVICE APPROVED RTF PLACEMENTS.
- 55 - BH MEDICALLY NECESSARY RTF, D&A PLACEMENT FROM COUNTY TO COUNTY WITHIN THE SAME MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE.
- 56 - BH MEDICALLY NECESSARY RTF PLACEMENT FROM COUNTY NOT IN MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE TO A COUNTY WITHIN A HEALTHCHOICES ZONE OR ANOTHER COUNTY NOT IN A HEALTHCHOICES ZONE; OR FROM A COUNTY WITHIN ONE HEALTHCHOICES ZONE TO A COUNTY WITHIN A DIFFERENT HEALTHCHOICES ZONE.
- 57 - BH MEDICALLY NECESSARY PLACEMENT INTO A NON-HOSPITAL D&A FACILITY FROM COUNTY TO COUNTY WITHIN THE SAME MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE.
- 58 - BH MEDICALLY NECESSARY PLACEMENT INTO A NON-HOSPITAL D&A FACILITY FROM COUNTY NOT IN MANDATORY MANAGED CARE (HEALTHCHOICES) ZONE TO A COUNTY WITHIN A HEALTHCHOICES ZONE OR ANOTHER COUNTY NOT IN A HEALTHCHOICES ZONE; OR FROM A COUNTY WITHIN ONE HEALTHCHOICES ZONE TO A COUNTY WITHIN A DIFFERENT HEALTHCHOICES ZONE.
- 60 - CAS-BH MEDICALLY NECESSARY MENTAL HEALTH RTF (WITHIN SAME BH NE ZONE) - THIS IS FOR PLACEMENT OF A CHILD IN SUBSTITUTE CARE (CSC) INTO A MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY. IT IS USED WHEN A CHILD IS PLACED IN A COUNTY WITHIN THE SAME HEALTHCHOICES BH NE ZONE AS THE CHILD'S COUNTY OF RECORD. THE PLACEMENT IS TO BE PRIOR APPROVED BY THE BH-MCO OR FEE-FOR-SERVICE. IF THE PLACEMENT IS NOT APPROVED BY THE BH-MCO OR FEE-FOR-SERVICE PROGRAM, FACILITY/PLACEMENT CODE 04 SHOULD BE USED.
- 61 - CSC-BH MEDICALLY NECESSARY MENTAL HEALTH RTF (OTHER THAN CODE 60) - THIS IS FOR PLACEMENT OF A CHILD IN SUBSTITUTE CARE (CSC) INTO A MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY. THIS CODE IS TO BE USED FOR A CHILD FROM THE BH NE ZONE BEING PLACED IN SUBSTITUTE CARE THAT DOES NOT MEET THE 60 CRITERIA DESCRIBED ABOVE. THE PLACEMENT IS TO BE PRIOR APPROVED BY THE BH-MCO OR FEE-FOR-SERVICE. IF THE PLACEMENT IS NOT APPROVED BY THE BH-MCO OR FEE-FOR-SERVICE PROGRAM, FACILITY/PLACEMENT CODE 05 SHOULD BE USED.
- 62 - CSC - NON-HOSPITAL RESIDENTIAL DRUG AND ALCOHOL FACILITY - WITHIN BH NE ZONE. THIS IS FOR PLACEMENT OF A CHILD IN SUBSTITUTE CARE (CSC) INTO A NON-HOSPITAL D&A FACILITY (RESIDENTIAL TREATMENT FACILITY THAT DOES NOT PROVIDE 24 HOUR PHYSICIAN MONITORING). IT IS USED WHEN A CHILD IS PLACED IN A COUNTY WITHIN THE SAME BH NE HEALTHCHOICES ZONE AS THE CHILD'S COUNTY OF RECORD. THE PLACEMENT IS TO BE PRIOR APPROVED BY THE BH-MCO. IF THE PLACEMENT IS NOT APPROVED BY THE BH-MCO, FACILITY/PLACEMENT CODE 04 SHOULD BE USED.
- 63 - CSC - NON-HOSPITAL RESIDENTIAL DRUG AND ALCOHOL FACILITY - OUT OF NE ZONE. THIS IS FOR PLACEMENT OF A CHILD IN SUBSTITUTE CARE (CSC) INTO A NON-HOSPITAL D&A FACILITY (RESIDENTIAL TREATMENT FACILITY THAT DOES NOT PROVIDE 24 HOUR PHYSICIAN MONITORING). THIS CODE IS TO BE USED FOR A CHILD FROM THE BH NE HEALTHCHOICES ZONE BEING PLACED IN SUBSTITUTE CARE THAT DOES NOT MEET THE 62 CRITERIA DESCRIBED ABOVE. THE PLACEMENT IS TO BE PRIOR APPROVED BY THE BH-MCO. IF THE PLACEMENT IS NOT APPROVED BY THE BH-MCO, FACILITY/PLACEMENT CODE 05 SHOULD BE USED.
- 73 - YDC/YFC
- 74 - JDC
- 98 - MEDICALLY NECESSARY OUT-OF-STATE RTF PLACEMENT
- 99 - PLACEMENT OUT-OF-STATE INCLUDING NON-HOSPITAL D&A FACILITIES REGARDLESS OF MEDICAL NECESSITY.
- PI - PACIFIC ISLANDER AS - ASIAN
- HI - HISPANIC/LATINO UN - UNABLE TO DETERMINE

Safe Haven Fact Sheet for Hospitals
1-866-921-SAFE (7233)
www.secretsafe.org

Health Care Professionals

Overview

Act 201 of 2002, also known as The Newborn Protection Act, provides that a parent of a newborn may leave the child in the care of a hospital without being criminally liable providing that the following criteria are met:

- The parent expresses orally or through conduct that they intend for the hospital to accept the child; and
- The newborn is not a victim of child abuse or criminal conduct.

A newborn is defined by this act as a child less than 28 days of age as reasonably determined by a physician.

For the purposes of newborn protection a hospital is defined as follows:

- An institution having an organized medical staff which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services for the care or rehabilitation of people who are injured, disabled, pregnant, diseased, sick or mentally ill. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for people with mental illness or those facilities primarily engaged in providing rehabilitation services or long- term care.

Pennsylvania's program for newborn protection is known as "**Safe Haven.**"

What Does Safe Haven Mean For Your Hospital?

When a Newborn is Brought to Your Facility

- A physician, the director, or a person specifically designated by the director of a hospital may take a newborn into protective custody pursuant to the Newborn Protection Act.
- The child is immediately eligible for Medicaid when taken into protective custody.
- The local county children and youth agency is responsible for completing the newborns Medicaid process.
- The hospital must perform a medical evaluation of the newborn and any act necessary to care for and protect the physical health and safety of the child.
- The hospital is required to notify the local county children and youth agency and law enforcement immediately by telephone when a newborn is received.

- One copy of the written report, the Relinquished Newborn Report Form for Hospitals, must be submitted by the hospital within 48 hours of providing the oral report to the local county agency and law enforcement agency to:
 - Local county children and youth agency who receives custody of the newborn;
 - Local municipal Police Department or the Pennsylvania State Police where no municipal police jurisdiction exists; and
 - Pennsylvania Department of Public Welfare (DPW), Office of Children, Youth and Families.

Other Responsibilities

- Ensure staff is familiar with the Act and distribute materials provided by the DPW; and
- Adopt a written policy in accordance with the provisions of the Newborn Protection Act.

Immunity and Penalties

- No hospital nor health care provider at a hospital shall be subject to civil liability or criminal penalty solely by reason of complying with the Newborn Protection Act. (23 Pa.C.S. §6507) (relating to immunity granted to health care providers and hospitals)
 - Except for failure to report acceptance
- Failure to report acceptance (23 Pa.C.S. §6506) (relating to failure to report acceptance of newborns)
 - 1st intentional or knowingly failure to report -summary offense; and
 - 2nd or subsequent failure to report -misdemeanor of the third degree.

Pennsylvania's Safe Haven Web site, www.secretsafe.org, is tailored to expectant mothers, however, they as well as agencies, hospitals, etc. may download all educational materials related to the program.

**Safe Haven Fact Sheet
for County Children and Youth Agency**

1-866-921-SAFE (7233)
www.secretssafe.org

Children and Youth Agency

Overview

Act 201 of 2002, also known as The Newborn Protection Act, provides that a parent of a newborn may leave the child in the care of a hospital without being criminally liable providing that the following criteria are met:

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Pennsylvania's program for newborn protection is known as "**Safe Haven.**"

What Does Safe Haven Mean For Your Agency?

When a provider at a hospital takes protective custody of a newborn pursuant to the Newborn Protection Act, the provider is required to contact the local children and youth agency and law enforcement officials. In addition to what your agency would normally do when notified by a hospital that a child has been taken into protective custody the Newborn Protection Act requires your agency to do the following:

- Make diligent efforts within 24 hours to identify parent, guardian, custodian or other family member whereabouts.
- Request Law Enforcement Officials (LEO) to utilize resources associated with National Crime Information Center (NCIC).

- Assume responsibility for making decisions regarding newborn's medical care.
- Provide outreach and counseling services to prevent newborn abandonment.
- Continue prevention of newborn abandonment publicity and education program.
- Submit a written report, the Relinquished Newborn Report Form for the County Children and Youth Agency, within 72 hours of assuming custody of the newborn, to the Department of Public Welfare, Office of Children, Youth and Families.
- Submit an updated Relinquished Newborn Report Form anytime new information becomes available.

Pennsylvania's Safe Haven Web site, www.secretssafe.org, is tailored to expectant mothers however, as agencies are encouraged to download all educational materials related to the program.