

Kentucky Department for Community Based Services

# Safety Plan

Adult Name: \_\_\_\_\_ Social Service Worker: \_\_\_\_\_

For each safety concern and/or identified threat, describe the immediate safety intervention to be implemented to address the issue:

Safety concern/identified threat (list all which apply):

Intervention to keep Adult safe (list all which apply):

Observation and documentation of outcomes(who will observe and document outcomes):

This plan is valid for fourteen (14) working days from the signing date. It will expire on:  
The plan may be extended voluntarily with the agreement of all parties.

This voluntary agreement may be revoked at any time. If a change occurs, immediately contact your social service worker at \_\_\_\_\_.

In case of an emergency, please call 911.

The undersigned understand this document is not a court order. It is a voluntary agreement between the signed parties. All parties listed above on the intervention must sign below. Identify your relationship with the adult on the signature line.

Adult:	_____	Date:	_____
Guardian:	_____	Date:	_____
Other:	_____	Date:	_____
Other:	_____	Date:	_____
Other:	_____	Date:	_____
Other:	_____	Date:	_____
SSW:	_____	Date:	_____