Safe Haven Designated Facility Surrender Form

Please read the instructions before completing this form
Use black ink when completing the form in print

- Within 24 hours after receiving a Safe Haven newborn, the designated facility must notify the Local Department of Social Services (LDSS).
- All designated facilities (as described in Maryland Courts and Proceedings §5–641) receiving a Safe Haven newborn must notify law enforcement immediately after receiving a Safe Haven newborn to confirm that the newborn has not been reported missing, and arrange for the newborn to be transported to a hospital in Maryland to determine medical certainty and medical condition of the newborn.
- Submit this completed form to the LDSS in the respective jurisdiction where the Safe Haven newborn was surrendered.

For additional questions please call the Maryland Department of Social Services' Hotline at 1-800-91PREVENT (1-800-917-7383)

Section A:

Completed by the mother and/or responsible adult when possible.

Note to the mother or responsible adult: While providing this information is voluntary, any details you share can greatly assist in planning for the child's future care. As children grow, questions or situations may arise that only a parent can address.

1. Full name and relationship of person surrendering newborn (*may remain anonymous*):	First Name: Middle Name (if applicable): Last Name: Relationship:	
2. Full name and date of birth of newborn: D.O.B Format MM/DD/YYYY	First Name: Middle Name (if applicable): Last Name: Date of Birth:	
3. Sex and race of newborn:	Sex: -Select- Race:	
4. List any medications or known medical needs of newborn:		
5. Full name of newborn's birth parents (*may remain anonymous*):	**Parent 1** First Name: _____ Middle Name (if applicable) _____ Last Name: _____	**Parent 2** First Name: _____ Middle Name (if applicable) _____ Last Name: _____
6. Is there any intent to return the newborn?	Yes ☐	No ☐

7. Date newborn surrendered: Date Format MM/DD/YYYY		
Section B:		
Completed by all designated facility staff upon voluntary submission of the newborn who meets the Safe Haven Program criteria. (Law enforcement, Fire company, Medical office, and Hospital)		
1. Name, Title, and Phone Number of Staff Who Initially Received the Newborn:	Name: Title: Phone #:	
2. Designed Facility name and address:	Name: Address:	
3. Name of Newborn (if provided):	First Name: Middle Name (If applicable): Last Name:	
4. Sex and Race of Newborn:	Sex: -Select- Race:	
5. Actual or estimated date of birth of newborn (if known): D.O.B Format MM/DD/YYYY		
6. Name and relationship of person who surrendered the newborn (if provided or known). *Please provide description of the individual if name and relationship unknown or not disclosed:		
7. Has a missing person search been initiated with law enforcement?	Yes ☐	No or UNKNOWN ☐
If yes, date, time, name of law enforcement agency notified, and individual spoken to:	Date: Time: Law Enforcement Agency Notified: Individual Spoken To:	
8. Name and address of hospital newborn transported to for medical certainty and exam:	Hospital Name: Hospital Address:	
9. Date and time newborn transported to hospital	Date:	Time:
10. Name, title, and contact information of staff completing form (if different from the staff who initially received the newborn):	Staff First Name: Staff Middle Name (If Applicable): Staff Last Name: Staff Title: Staff Contact Information:	
11. Notification to LDSS Date, Time, and Name of Individual Receiving Notification:	Notification to LDSS Date: Time: Name of Receiving Individual:	