U.S. Department of Health and Human Services

OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

OFFICE OF REFUGEE RESETTLEMENT
Division of Children's Services
CARE PROVIDER FACILTY TOUR REQUEST

Please complete Section 1 of this form and submit it to your point of contact within HHS. All requests must be submitted no later than **TWO WEEKS** before the requested visit date. Unscheduled visits will not be accommodated.

Times and dates of visits will be confirmed based on shelter availability, taking into account operational and privacy concerns at site locations. Media is prohibited from accompanying visitors. You will receive notification of the visit approval as soon as it is processed. Questions regarding your request can be directed to your initial point of contact or UCTourRequests@acf.hhs.gov.

SECTION 1 *(to be completed by the requester)*

A. REQUESTER POINT OF CONTACT

Name: **Organization:**

Email: **Phone:**

B. REQUESTED DATE AND LOCATION

Date and Time Requested:

Are the date and time requested flexible? ☐ Yes ☐ No

Location Requested *(city, region, or specific care provider facility)***:**

Depending on the capacity of the requested location, are you able and willing to visit a different care provider facility to accommodate your requested visit date? ☐ Yes ☐ No

Purpose of Visit:

C. ADDITIONAL NOTES OR ACCOMADATION REQUESTS

D. REQUESTED VISITORS *(add or delete rows as needed)*

Name	**Title and Organization** *(include driver's license number if tour location is an Influx Care Facility)*

SECTION 2 *(to be completed by ORR)*

A. TYPE OF VISITOR

Requires ACF or ORR DCS Headquarters Approval:

- ☐ Advocates *(includes religious groups)*
- ☐ Congressional
- ☐ Consular Visits *(non-standard)*
- ☐ Federal Agencies
- ☐ International *(non-consular)*
- ☐ State/Local Officials
- ☐ Media

Requires FFS Supervisor or Project Officer Supervisor Approval:

- ☐ Outside Group Events *(religious services, holiday parties, etc. held by outside groups)*
- ☐ Students

******Please refer any requests from attorneys directly to ORR Division of Policy and do not complete this form******

B. DECISION

Visit Approved? ☐ Yes ☐ No

Special Instructions for Visitors:

Approving Official or Entity: **Date:**

C. APPROVED DATE AND LOCATION

Date and Time:

Care Provider Facility Name:

Care Provider Facility Address:

D. ORR POINT OF CONTACT

Name:

Email:

Phone:

E. APPROVED VISITORS *(add or delete rows as needed)*

Name	**Title and Organization** *(include driver's license number if tour location is an Influx Care Facility)*