



**OFFICE OF REFUGEE RESETTLEMENT**  
**Division of Children's Services**  
**CARE PROVIDER FACILITY 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](mailto: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 <i>(include driver's license number if tour location is an Influx Care Facility)</i>

**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 <i>(include driver’s license number if tour location is an Influx Care Facility)</i>