Assessment for Risk

UAC Basic Information

First Name:

Last Name:

AKA:

Status:

Date of Birth: Gender:

A No.: LOS:

Age: Current Program:

Child's Country of Birth: Admitted Date:

Assessment for Risk

INSTRUCTIONS: A care provider facility Clinician or Qualified Case Manager must complete the Assessment for Risk in the ORR database within 72 hours of a child or youth's admission. It must be updated every 30 days. The purpose of the assessment is to identify risk factors for potential sexual victimization or sexual abuser tendencies so early intervention can take place to mitigate any potential risks or safety concerns. Although the assessment presents a specific list of questions, the Clinician or Qualified Case Manager is expected to draw upon his/her professional training to obtain any additional information that may contribute to a thorough assessment. The assessment includes questions that the Clinician or Qualified Case Manager obtains from the child or youth as well as questions that the Clinician or Qualified Case Manager must answer based on his/her professional assessment of the individual case.

Child's Primary Language:

Intake conducted in what language:

INFORMATION CLINICIANS OR QUALIFIED CASE MANAGERS OBTAIN FROM CHILD OR YOUTH

1. **Do you feel safe in your current room assignment or the assignment that will be given to you?** ◉ Yes ○ No
   If No, explain:

2. **Has anyone made any inappropriate comments to you about your body, clothes, or appearance that made you uncomfortable at this facility?** ○ Yes ◉ No
   If Yes,explain:

3. **Do you identify as:**
   - ☐ Decline to Answer
   - ☑ Straight
   - ☐ Lesbian
   - ☐ Gay
   - ☐ Bisexual
   - ☐ Questioning
   - ☐ Intersex-Identify as Male
   - ☐ Intersex-Identify as Female
   - ☐ Transgender: If checked, choose one: ○ Male to Female ○ Female to Male ○ Other, Specify
   - ☐ Other, Specify:

4. **If the child or youth identified as Transgender or Intersex, Click Here:** ☐
   If you clicked the box, then answer the following:
   (a) Ask whether the child or youth would rather be housed with boys or girls?:
   ○ Housed with Boys ○ Housed with Girls ○ No Preference
   (b) Ask whether the child or youth would rather have a female or male staff member conduct a pat down search if one is necessary:
   ○ Male Staff ○ Female Staff ○ No Preference

5. **Do you feel safe telling people about your sexual preference or gender identity since you have been here?** ◉ Yes ○ No ○ Decline to Answer
   If No, explain:

6. **Is there something that you think we can do to help you feel safe and comfortable while you are here?** ○ Yes ◉ Not at this time
   If Yes, explain:

7. **Do you find that people make a lot of sexual comments to you or about you?*** ○ Yes ◉ No ○ Decline to Answer
   If Yes, explain:

8. **Have you ever been sexually active?**
   - ○ Decline to Answer, Explain:
   - ◉ Yes. If yes, pick one: ◉ With Males Only ○ With Females Only ○ With both Males and Females ○ Decline to Answer
   - ○ No
   - ○ Other, Specify:

If you click Yes above, please ask the following: Have you ever had a sexual experience that was not consensual? ◉ Yes ○ No ○ Decline to Answer
Explain:

9. **Have you ever felt like you needed to perform sexual favors or allow someone to touch your body in a sexual way in order to avoid additional harm, to obtain something you needed or wanted, or to be accepted by a person or group of people?** ○ Yes ◉ No ○ Decline to Answer
If Yes, explain:

10. **Have you ever spoken to a counselor, social worker, psychologist, teacher, or any other adult because of a sexual experience you had?** ○ Yes ◉ No ○ Decline to Answer
If Yes, explain:

INSTRUCTIONS: After interviewing the child or youth and reviewing relevant case files and other records, Clinicians and Qualified Case Managers must use their professional opinion to answer the following questions.

QUESTIONS FOR CLINICIANS OR QUALIFIED CASE MANAGERS TO ANSWER

1. **Does the child or youth exhibit any gender nonconforming appearance or manner?** ○ Yes ◉ No
If Yes, explain:

2. **Does the child or youth have any current or past criminal charges?** ○ Yes ◉ No
If Yes, List the Charges and Explain:

3. **Does the child or youth have any mental, physical, or developmental disability or illness or suspected of having any of the above?**
◉ No
○ Yes ☐ Mental ☐ Physical ☐ Developmental
Explain: n/a
○ Suspected ☐ Mental ☐ Physical ☐ Developmental
Explain: n/a

4. **What is the child's physical size and stature?** ◉ Average ○ Smaller than Average ○ Larger than Average

5. **Other specific information that may indicate heightened needs and/or additional safety precaution:** ○ Yes ◉ No
If Yes, explain:

INSTRUCTIONS: After completing the above assessment, determine if any housing and other service assignments are needed to ensure the safety and well-being of the child or youth. Describe housing and other service assignments here. Indicate specific actions and follow-up. If housing and other service assignments are changed at any time, including after the initial placement, describe the change and the reason for the change here.

HOUSING, OTHER SERVICE ASSIGNMENTS, AND FOLLOW-UP

1. **Housing and Other Service Plan**

2. **If the child or youth identified as Transgender or Intersex, Click Here:** ☐
If you clicked the box, answer the following:
(a) The child or youth was placed in a room/dormitory that reflects the minor's preference ○ Yes ○ No
Explain:
(b) The child or youth was placed in educational or activities group(s) to reflect the minor's preference ○ Yes ○ No
Explain:

3. **Actions Taken (Mark all that apply)**
☐ **Clinician or Qualified Case Manager shared appropriate information with relevant care provider facility team**
Explain:

☐ **Child or youth provided with psycho education on identified issue**
Explain:

☑ **Child or youth provided with information on how to report threats, intimidation, or harassment by other children, youth, or facility staff**
Explain:

☐ **Developed and implemented an in care safety plan between child or youth, clinician, and care provider staff to address a specific issue**
Explain:

☐ **Child or youth provided with additional or alternate restroom accommodations**
Explain:

☐ **Implemented increased clinical sessions**
Explain:

☐ **Child or youth referred for professional/external mental health services**
Date of Referral:
Explain:

☐ **Child or youth referred for medical services**
Date of Referral:
Explain:

☐ **Child or youth placed on closer staff supervision**
Explain:

☐ **Staffed with FFS and CC for possible transfer**
Explain:

☐ **Other**
Explain:

☐ **Other Attachments**

☐ **No specific action taken**
Explain:

Staff Signature: **Date/Time:**

Staff Name:

Staff Title:

Translator's Signature: **Date/Time:**

Translator's Name:

Language: