

UAC Case Review

UAC Basic Information

First Name:

Test

Last Name:

testthree

AKA:

Status: ADMITTED

Date of Birth: 4/6/2005

Gender: M

A No.: 471717171

LOS: 0

Age: 14

Current Program: A New Leaf – Dorothy Mitchell

Country of Birth: Afghanistan

Admitted Date: 4/2/2020

30 day Case Review Discharge Transfer

Are there any changes?:

Yes No

Previous Placement:

Religious Affiliation:

Case Manager:

Clinician:

Document any new information regarding the UAC not indicated in the UAC Assessment and/or the previous case summary below

Medical

List any allergies:

Do you feel unwell?

Yes No

If yes, what are your symptoms?

Additional medical information:

Medical History

Condition	Yes/NO	Date of Diagnosis/Clarification
Pregnant	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Tuberculosis	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Varicella	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Measles	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Mumps	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Rubella	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Asthma	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Diabetes	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Cancer	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Cardiac Issues	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Sexually Transmitted Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Respiratory/Lung Disorder	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Physical Disability	<input type="radio"/> Yes <input checked="" type="radio"/> No	

Medication History

Medication	Dosage	Timeframe	Medical Condition

Legal

Know Your Rights Presentation provided? Yes No

Date:

Legal screening completed? Yes No

Date:

Any possible legal relief identified? Yes No

Specify:

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to document new information obtained after completion of the UAC Assessment. Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (Homeland Security Act, 6 U.S.C. 279). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. If you have any comments on this collection of information please contact UACPolicy@acf.hhs.gov.

Mental Health

Provide a short summary of the UAC's current functioning:

Psychological Evaluation

Date of Evaluation:

Evaluator:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Summary of Recommendations:

Trafficking

Who planned/organized your journey?

What were you told about the arrangements before the journey?

Did the arrangements change during the journey?

Yes No

If yes, how?

Does your family owe money to anyone for the journey?

Yes No

If yes, how much?

Whom is the money owed?

Who is expected to pay?

What do you expect to happen if payment is not made?

Coercion Indicators

Did anyone threaten your or your family?

Yes No

If yes, who made the threats?

Were you ever physically harmed?

Yes No

If yes, how?

Was anyone around you ever physically harmed?

Yes No

If yes, who?

Were you ever held against your will?

Yes No

If yes, where?

Did anything bad happen to anyone else in this situation or anyone else who tried to leave?

Yes No

What happened and to whom?

Did anyone ever keep/destroy your documents?

Yes No

If yes, who and what?

Did anyone ever threaten to report you to the police/immigration?

Yes No

If yes, who?

Are you worried anyone might be trying to find you?

Yes No

If yes, who?

Debt Bondage/ Labor Trafficking

Did you perform any work or provide any services?

Yes No

If yes, what and where?

Who arranged the work?

What type of work did you perform?

What was the work schedule?

Did work conditions change over time?

Is there a debt?

Yes No

If yes, has any debt amount increased?

Yes No

By how much?

When did it increase?

Why did it increase?

Have you or your family ever been threatened over payment or work for the journey?

Yes No

If yes, who threatened you and how?

What did you expect would happen if you left the job or stopped working?

Were you ever made to work or do anything you did not want to do?

Yes No

Did you receive pay or did someone else keep the pay?

Were you paid what was promised when you started working?

Were expenses taken out of the pay?

Yes No

If yes what?

How did you get to the work site?

Where did you live while working?

Commercial Sex Indicators

Did anyone ever ask you to see you naked or in your underwear in exchange for money/anything of value?

Yes No

Did anyone ever pay/accept money/anything of value from other people in order to see you naked or in your underwear?

Yes No

Did anyone ever ask to take pictures or recording of you naked or engaged in sex acts?

Yes No

If so, did they offer you money/anything of value to do this or did they accept money/anything of value from others in order to see these pictures or recordings?

Yes No

Did anyone ever ask or expect you to perform sexual acts in exchange for money/anything of value?

Yes No

Did anyone ever promise or give money or anything of value to you in exchange for sexual acts?

Yes No

Based on the information provided above in the "Trafficking" section, is there a trafficking concern?

Yes No

If yes, date of trafficking referral:

Sponsor Information (List by Priority)

Current Sponsor	Cat (1,2,3)	Sponsor Name	DOB	Address	Phone	Legal Status	Relationship
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Sponsor Risk Assessment

Substance use concerns? Yes No

If yes, explain:

Domestic violence concerns? Yes No

If yes, explain:

Child abuse or neglect concerns? Yes No

If yes, explain:

Mental health issues? Yes No

If yes, explain:

Does the sponsor have any family support? Yes No

Specify:

Does the sponsor have any identified special needs? Yes No

If yes, explain:

Does the sponsor have financial needs? Yes No

If yes, explain:

Does the sponsor have adequate housing? Yes No

If yes, explain:

Are there any concerns with the disciplinary practices/philosophy of sponsor?

Does the sponsor have any criminal history? Yes No

List any Felony convictions:

List any Misdemeanor convictions:

List any Probation/Parole:

List and describe any disclosed criminal activity:

History of Incarceration:	Crime	Date	Length of Sentence	Location
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Are there any parent/child relational issues? Yes No

If yes, explain:

Does the sponsor have an Order of Removal? Yes No

If yes, date issued:

Has the sponsor sponsored any other UAC in DCS care? Yes No

Additional sponsor information:

Sponsor Sponsored UACs:	Name of UAC	A Number	Relationship	Facility sponsored from
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Mandatory TVPRA 2008

Based on the most recent trafficking screening, is the child a victim of a severe form of trafficking in persons? (Indicate 'yes' only if ORR has issued a trafficking eligibility letter for UAC.) Yes No

Date eligibility letter issued:

Based on the most recent screening for disabilities, does the child have a disability as defined in section 3 of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12102(1)? Yes No

If yes, specify disability:

Based on the most recent screening, has the child been a victim of physical or sexual abuse under circumstances that indicate that the child's health or welfare has been significantly harmed or threatened? Yes No

If yes, provide a short summary:

Based on the sponsor risk assessment, does the sponsor clearly present a risk of abuse, maltreatment, exploitation, or trafficking to the UAC? Yes No

If yes, provide a short summary:

Recommendations

Discharge: Yes No

Sponsor:

Discharge w/ Post Release: Yes No

Date of PR referral:

Refer to Home Study Yes No

Reason for HS referral:

Care Plan

Reunification:

Legal:

Mental Health:

Certification

Signature:

Date:

Print Name:

Title:

