OMB 0970-0547 [Valid through MM/DD/YYYY]

UAC Basic Information

	First Name:	Status:
	Last Name:	AKA:
	Date of Birth:	Gender:
	A No.:	LOS:
	Age:	LOC:
	Child's Country of Birth:	Current Program:
	Admitted Date:	
	ORR Placement Date:	Current Location:

Event Type: SIR Event

Date of Event:	Time of Event:	Event ID:

Synopsis of Event:

Significant Incident Report

◉ Emergency SIR ○ SIR

Emergency SIR

☐ Death of a UC in ORR Custody ---Select---		
☐ Medical Emergency		
☐ Abuse/Neglect in ORR Care	Type of Abuse: ---Select---	Alleged Perpetrator: ---Select---
☐ Behavioral Incidents that threaten immediate safety	☐ Use of a Weapon ☐ Harm to Others ☐ Other	☐ Self-Harm with medical intervention ☐ Suicide Attempt/Gesture

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to allow ORR care provider programs to inform ORR of urgent situations in which there is an immediate threat to a child's safety and well-being that require instantaneous action. Public reporting burden for this collection of information is estimated to average 0.333 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 UCPolicy@acf.hhs.gov.

☐ Mental Health Emergency Requiring Hospitalization		
☐ Unauthorized Absence	○ Escape	○ Attempted Escape
☐ Other Specify:		

Incident Information:

Did the incident take place at another care provider facility? ○ Yes ◉ No **Care Provider Name:** -- Select Provider Name --

Care Provider City: -- Select Provider City -- **Care Provider State:** -- Select Provider State --

Location of Incident:

Date Reported To Care Provider:

Time Reported To Care Provider:

DHS Facility/Custody:

Date Reported To ORR:

Time Reported To ORR:

Description of Incident: (Full Description of Incident)

Was the UAC or Anyone Else Injured?: ○ Yes ◉ No **Specify:**

Actions Taken

Staff Response and Intervention

Follow-up and/or Resolution:

Recommendations:

Reporting:

Reported To State Licensing: ○ Yes ◉ No **Date of Report:** **Time of Report:**

Was the Incident Investigated? ○ Yes ○ No **Date Notified the Incident will be investigated:** **Case/Confirmation Number:**

Explain

Results/Findings of Investigation:

Attach Reports/Findings:

Is CPS Different From State Licensing: ◯ Yes ◉ No

Reported To CPS: ◯ Yes ◯ No **Date of Report:** **Time of Report:**

Was the Incident Investigated? ◯ Yes ◯ No **Date Notified the Incident will be investigated:** **Case/Confirmation Number:**

Explain

Results/Findings of Investigation:

Attach Reports/Findings:

Reported To Local Law Enforcement: ◯ Yes ◉ No **Date of Report:** **Time of Report:**

Officer Name: **Officer Badge:**

Was the Incident Investigated? ◯ Yes ◯ No **Date Notified the Incident will be investigated:** **Case/Confirmation Number:**

Explain

Results/Findings of Investigation:

Attach Reports/Findings:

ORR Notifications:

Name	Agency/Title	Date Notified	Time Notified	Email	Telephone Number
	ORR/FFS				
	ORR/PO				
	Medical Coordinator				
	Case Coordinator				
	CFS				
	SIR Hotline				

Other Notifications:

Is this an SIR for a Runaway? ◯ Yes ◯ No

Title	Name	Date Notified	Time Notified	Method of Notification	Specify
ICE Juvenile Coordinator					

Reporter and Follow-Up Contact:

Type	Name	Title	Email	Telephone Number
Staff Filing Report				
Contact for Follow-Up				