

**UAC Basic Information**

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

**Event Type:** SIR Event

<b>Date of Event:</b>	<b>Time of Event:</b>	<b>Event ID:</b>
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**Synopsis of Event:**

**Significant Incident Report**

Emergency SIR  SIR

SIR

Abuse/Neglect in ORR Care    Sexual Abuse or Sexual Harassment    Alleged Perpetrator:

Sexual Abuse SIR

TYPE OF INCIDENT/INDIVIDUALS INVOLVED

<b>Type of Incident:</b>	<b>Type of Allegation:</b>
	<b>How was this UAC involved?</b>

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 allegations of sexual harassment, sexual abuse, and inappropriate sexual behavior. 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.

Were Other UAC Involved

Yes  No

Name	A-Number	Role	Specify

Were Staff Present of Involved in the Incident

Yes  No

Name	Title	Role	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:

Other Specify:

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

Actions Taken for Victim:

<b>Action Taken for Alleged Perpetrator:</b>			
<b>Follow-up Regarding Individuals Involved:</b>			
<b>Recommendations:</b>			
<b>Reporting:</b>			
<b>Reported To CPS:</b>	<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Date of Report:</b>	<b>Time of Report:</b>
<b>Was the Incident Investigated?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Date Notified the Incident will be investigated:</b>	<b>Case/Confirmation Number:</b>
<b>Progress of Investigation:</b>			
<b>Results/Findings of Investigation:</b>			
<b>Attach Reports/Findings:</b>			
<hr/> <hr/>			
<b>Is CPS Different From State Licensing:</b>	<input type="radio"/> Yes <input checked="" type="radio"/> No		
<b>Reported To State Licensing:</b>	<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Date of Report:</b>	<b>Time of Report:</b>
<b>Was the Incident Investigated?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Date Notified the Incident will be investigated:</b>	<b>Case/Confirmation Number:</b>
<b>Progress of Investigation:</b>			
<b>Results/Findings of Investigation:</b>			
<b>Attach Reports/Findings:</b>			
<hr/> <hr/>			
<b>Reported To Local Law Enforcement:</b>	<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Date of Report:</b>	<b>Time of Report:</b>
		<b>Officer Name:</b>	<b>Officer Badge:</b>
<b>Was the Incident Investigated?</b>	<input type="radio"/> Yes <input type="radio"/> No	<b>Date Notified the Incident will be investigated:</b>	<b>Case/Confirmation Number:</b>

Progress of Investigation:

Results/Findings of Investigation:

Attach Reports/Findings:

Reported To DOJ:

Yes  No

Date of Report:

Time of Report:

Notes:

ORR Notifications:

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

Other Notifications:

Title	Name	Date Notified	Time Notified	Method of Notification	Specify
Attorney of Record					
Parent/Legal Guardian					
Child Advocate (If Applicable)					

Reporter and Follow-Up Contact:

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