

UC Assessment (Form S-11)

UC Basic Information and Additional UC Information Tab

UAC Basic Information



First Name:

AKA:

Last Name:

Status:

Date of Birth:

Admitted Date:

A#:

Length of Stay:

Country of Birth:

Current Program:

Gender:

Portal ID:

ADDITIONAL UAC INFO

JOURNEY AND APPREHENSION

FAMILY/SIGNIFICANT RELATIONSHIPS

MEDICAL

EDUCATION

LEGAL

CRIMINAL HISTORY

MENTAL HEALTH/BEHAVIOR

TRAFFICKING

MANDATORY TVPRA 2008

ADDITIONAL INFORMATION

CERTIFICATION

Additional Basic UAC Information

City of Origin:

Neighborhood of Origin:

Previous Placement:

Religious Affiliation:

Case Manager:

Clinician:

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Journey and Apprehension Tab

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Journey and Apprehension

Describe day to day life in home country:

Why did you decide to travel to the U.S. as this time?

Did the child mention any U.S. immigration policy or practice as a factor in his/her decision to travel to the U.S. ? Yes No

For UAC aged 14-17 ONLY: Did the child mention economic, job, or educational opportunities as a factor in his/her decision to travel to the U.S.? Yes No

When did you leave your home country (month, day, year)?

How long did the trip take?

How did you get to the U.S.?

Who did you travel with?

Who were you living with when you decided to leave your home country?

Where were you planning on living in the U.S. and with whom?

Where were you apprehended?

At which U.S. Border Patrol sector did the child cross into the U.S.?

Have you ever been to the U.S. before? Yes No

If yes, when?

The child's experience and additional information regarding the journey and apprehension:

Family/Significant Relationships Tab

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Family/Significant Relationships

Has Family in Country of Origin? (If Yes No yes, list below)

Family in Country of Origin

Name	Age	DOB	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>	-- Select Relationship -- <input data-bbox="1911 1079 1942 1104" type="button" value=" v "/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	-- Select Relationship -- <input data-bbox="1911 1112 1942 1136" type="button" value=" v "/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	-- Select Relationship -- <input data-bbox="1911 1144 1942 1169" type="button" value=" v "/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	-- Select Relationship -- <input data-bbox="1911 1177 1942 1201" type="button" value=" v "/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	-- Select Relationship -- <input data-bbox="1911 1209 1942 1234" type="button" value=" v "/>

Has Family in the U.S.? (If yes, list below) Yes No

Family and Family Friends in the U.S.

>| Add New Row

Name	Age	DOB	Relationship
			-- Select Relationship --
			-- Select Relationship --
			-- Select Relationship --
			-- Select Relationship --
			-- Select Relationship --

Parent's whereabouts?

Are you married?

Yes No

Spouse Name, Age, and Location:

Has Children? (If yes, list below)

Yes No

Children

>| Add New Row

Name of Child	Age	DOB	Current Location	Name of Mother/Father

Have you ever been hurt by physically, mentally or emotionally by someone taking care of you?

Yes No

If yes, who and when?

Have you ever been taken to the hospital/emergency room because you were hurt? Yes No

If yes, explain:

What does the word "discipline" mean to you?

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Medical Tab

ADDITIONAL UAC INFO JOURNEY AND APPREHENSION FAMILY/SIGNIFICANT RELATIONSHIPS **MEDICAL** EDUCATION LEGAL CRIMINAL HISTORY
MENTAL HEALTH/BEHAVIOR TRAFFICKING MANDATORY TVPRA 2008 ADDITIONAL INFORMATION
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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	<input type="text"/>
Tuberculosis	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Varicella	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Measles	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Mumps	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Rubella	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Asthma	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Diabetes	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Cancer	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Cardiac Issues	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Sexually Transmitted Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Respiratory/Lung Disorder	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Physical Disability	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>

Medication History

>| Add New Row

Medication	Dosage	Timeframe	Medical Condition
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Education Tab

ADDITIONAL UAC INFO	JOURNEY AND APPREHENSION	FAMILY/SIGNIFICANT RELATIONSHIPS	MEDICAL	EDUCATION	LEGAL	CRIMINAL HISTORY
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Education

What is the highest level of education you have completed?

When was the last time you were in school? What age?

Legal Tab

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Legal

Know Your Rights	<input type="radio"/> Yes <input type="radio"/> No	When?:	<input style="width: 95%;" type="text"/>		
Presentation provided?					
Legal screening completed?	<input type="radio"/> Yes <input type="radio"/> No	When?:	<input style="width: 95%;" type="text"/>		
Notice to appear filed?	<input type="radio"/> Yes <input type="radio"/> No	When?:	<input style="width: 95%;" type="text"/>		
Scheduled for hearing?	<input type="radio"/> Yes <input type="radio"/> No	When?:	<input style="width: 95%;" type="text"/>		
		Where? State:	<input style="width: 150px;" type="text" value="-- Select a State - v"/>	City:	<input style="width: 150px;" type="text"/>
		Outcome:	<input style="width: 150px;" type="text" value="Select Outcome"/>		
Has attorney?	<input type="radio"/> Yes <input type="radio"/> No	Date of meeting:	<input style="width: 95%;" type="text"/>		
Any possible legal relief identified?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Specify:	<input style="width: 95%; height: 100%;" type="text"/>		

Criminal History Tab

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Criminal History

Any Criminal history? (If yes, list below) Yes No

List any Felony convictions:

List any Misdemeanor convictions:

List any Probation/Parole:

List and describe any disclosed criminal activity:

Additional information:

History of Incarceration >| Add New Row

Crime	Date	Length of Sentence	Location

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Mental Health/Behavior Tab

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Mental Health/Behavior

Mental Status Evaluation

Attitude

- Calm and Cooperative Other

If other, describe:

Behavior

- No Unusual Movements or Psychomotor Changes Other

If other, describe:

Speech

- Normal Rate/Tone/Volume Other

If other, describe:

Affect

- Please Select --- If other, describe:

Mood

- Please Select --- If other, describe:

Thought Process

- Goal-oriented and Logical Disorganized Other

If other, describe:

Thought Content

Suicidal Ideation	Homicidal Ideation
<input type="radio"/> None <input type="radio"/> Passive <input type="radio"/> Active If active: Plan <input type="radio"/> Yes <input type="radio"/> No Intent <input type="radio"/> Yes <input type="radio"/> No Means <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> None <input type="radio"/> Passive <input type="radio"/> Active If active: Plan <input type="radio"/> Yes <input type="radio"/> No Intent <input type="radio"/> Yes <input type="radio"/> No Means <input type="radio"/> Yes <input type="radio"/> No

If other, describe:

Perception

No Hallucinations or Delusions During Interview Other

Orientation

Time Place Person Self If other, describe:

Memory/Concentration

Short term intact Long term intact distractible/Inattentive If other, describe:

Insight/Judgment

Good Fair Poor

Mental Health

Have you ever talked to a psychiatrist, psychologist, therapist, social worker or counselor about an emotional problem? Yes No
 When:

Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? Yes No
 When:

Have you ever been advised to take medication for anxiety, depression, hearing voices or for any other emotional problems? Yes No
 When:

Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? Yes No
 When:

Have you ever heard voices no one else could hear or seen objects or things that others could not see? Yes No

When:

Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions or thought about killing yourself? Yes No

When:

Did you ever attempt to kill yourself? Yes No

When:

Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, murder, accident, being killed. Yes No

When:

Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to the destruction of property? Yes No

When:

Substance Use History

Substance	Used (even once)	Frequency of Use	Date of Last Use
Alcohol	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>
Marijuana	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>
Cocaine	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>
Other Stimulants (Meth, Ritalin, etc)	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>
Heroin	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	<input type="text"/>

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Trafficking Tab

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Trafficking

Who planned/organized your journey?

Did a family member or family friend pay for your travel to the U.S.?

Yes No

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 or family friend 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 you 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:

Mandatory TVPRA 2008 Tab

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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:

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Additional Information Tab

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Additional Information

Please input any additional information if needed:

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Certification Tab

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Certification

Signature:	<div style="border: 1px solid #ccc; height: 80px;"></div>	Date:	<input type="text"/>
		Print Name:	<input type="text"/>
		Title:	<input type="text"/>

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