

Assessment for Risk (Form S-9)

Data Entry Window

New Admission Assessment: Assessment for Risk

Assessment ID * Admission

* Assessment Status Submitted DateTime

Basic Information Tab

Admission Assessment
Assessment for Risk

Assessment ID: Assessment-00000074 Admission: [Entry-00001026](#) UAC

UAC Basic Information

A #	AKA	Gender
DOB	Age	COB
Status	Current Program	Admitted DateTime
LOC	LOS	Gender Other

Basic Information Assignments And Follow-Up Documents Certification

Assessment for Risk Basic Information

Primary Language Spoken

Intake Conducted in What Language

Pending Submitted

Assessment Status: Pending

Information Clinicians or Qualified Case Managers obtain from Child or Youth

Do you feel safe in your current room assignment or the assignment that will be given to you?

Select an Option ▼

If no, explain:

Has anyone made any inappropriate comments to you about your body, clothes, or appearance that made you uncomfortable at this facility?

Select an Option ▼

If yes, explain:

Do you identify as ⓘ

Available Options

Selected Options

Decline to Answer ▶
Straight ◀
Lesbian ◀
Gay
Bisexual
Questioning
Intersex-Identify as Male
Intersex-Identify as Female
Transgender ▼

Gender ⓘ

Select an Option ▼

Gender Other

Rather be housed with boys or girls? ⓘ

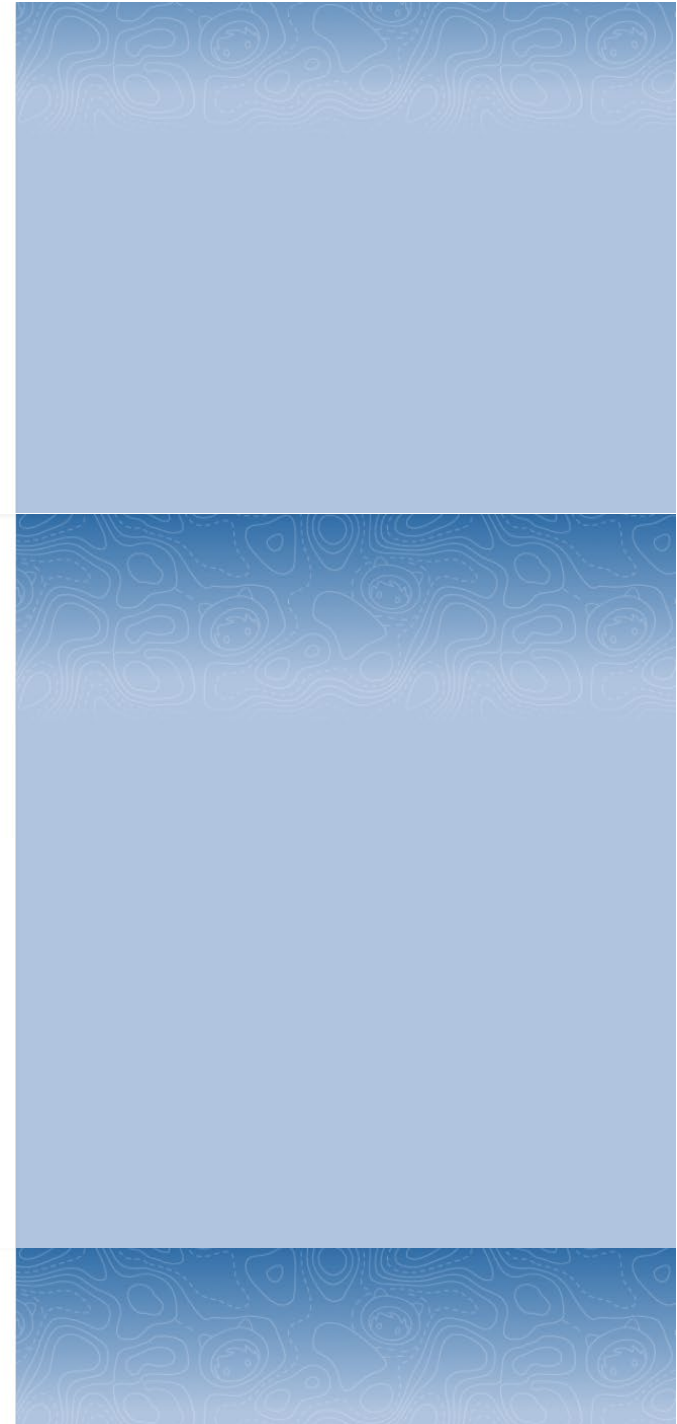
Select an Option ▼

Are pat down searches conducted by this care provider?

Select an Option ▼

Rather have a female or male staff member conduct a pat down search ⓘ

Select an Option ▼



Do you feel safe telling people about your sexual orientation or gender identity since you have been here?

Select an Option

If no, explain

Is there something that you think we can do to help you feel safe and comfortable while you are here?

Select an Option

If yes, explain

The remaining questions in this section should only be asked of children ages 10 and older.

Do you find that people make a lot of sexual comments to you or about you?

Select an Option

If yes, explain

Has the minor ever agreed to perform a sexual act or allow his or her body to be touched for any of the following: to avoid harm to self or others, to get something he or she needed or wanted; or to be accepted by others?

Select an Option

If yes, explain

*Do you have a history of sexual activity?

Select an Option

Sexual Activity Type 

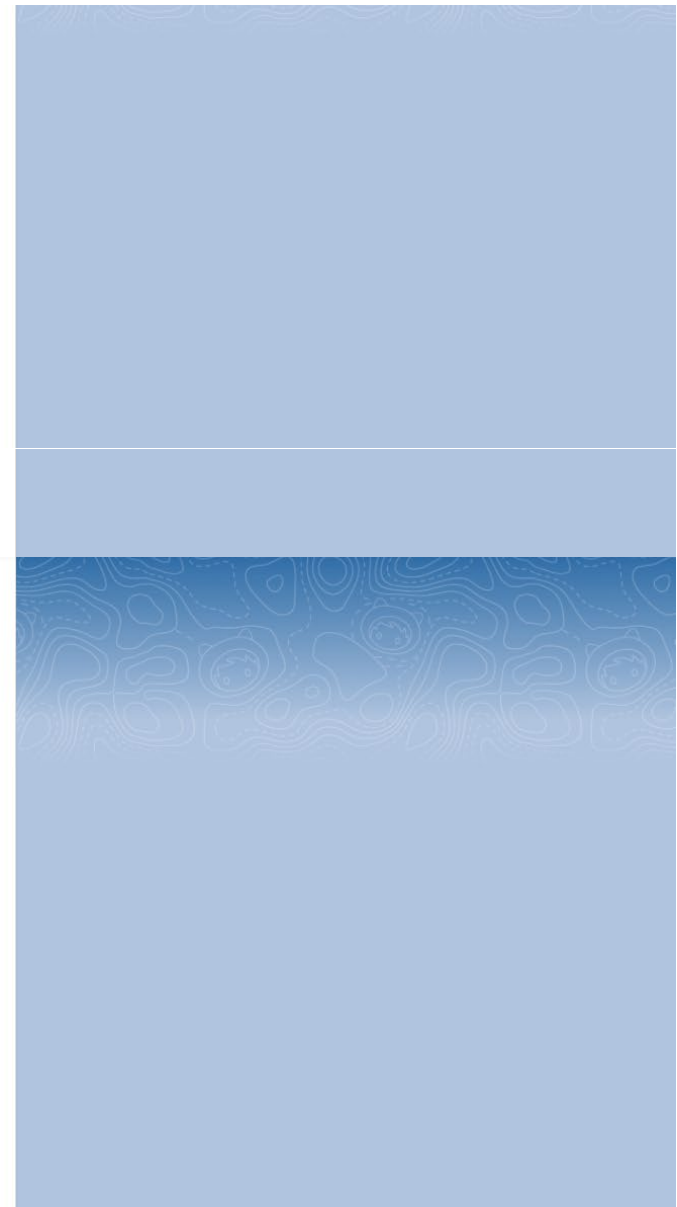
Available Options

Oral

Vaginal

Anal

Selected Options



Was the sexual activity consensual? ⓘ

Select an Option ▼

Date of Last Consensual Sexual Encounter ⓘ

📅

Approx. Date of Last Consensual Sexual Encounter ⓘ

In Home Country? ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

During Journey to U.S.? ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

In ORR Custody? ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

In US, not in ORR Custody? ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

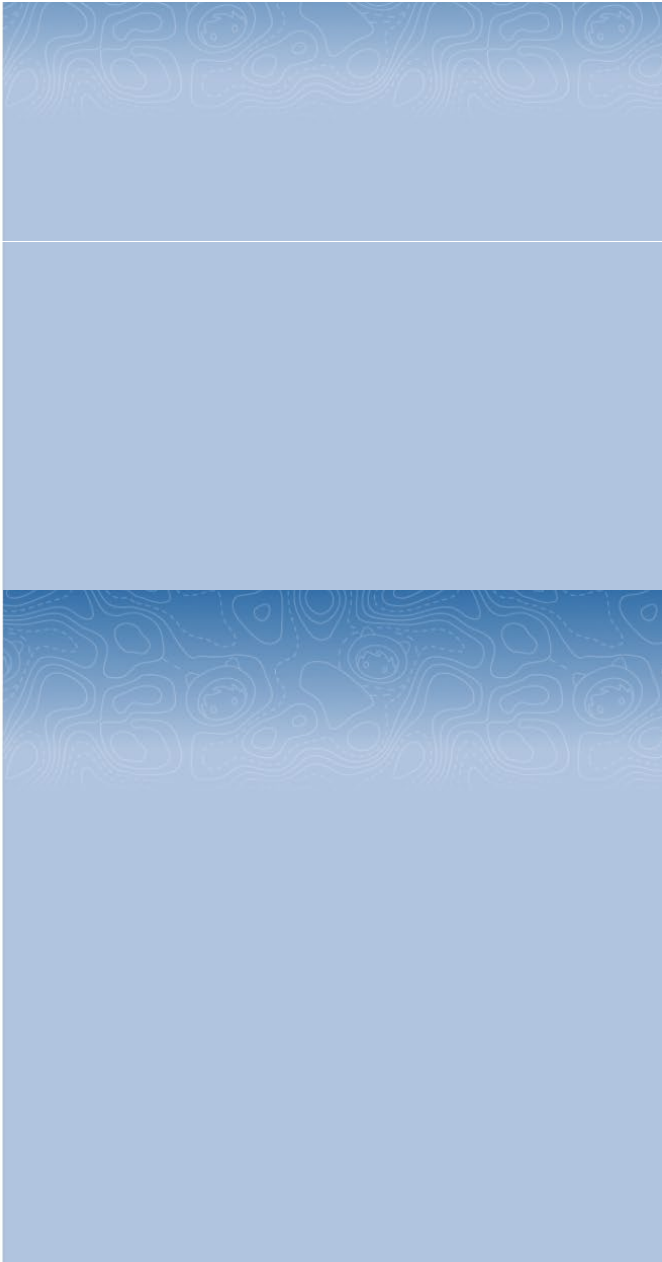
Was the sexual activity history non-consensual sexual activity? ⓘ

Select an Option ▼

Date of Last Non-Consensual Encounter ⓘ

📅

Approx. Date of Last Non-Consensual Sexual Encounter ⓘ



In Home Country ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

During Journey to U.S. ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

In ORR Custody ⓘ

Select an Option ▼

Specify Who/When/Where ⓘ

In US, not in ORR Custody ⓘ

Select an Option ▼

Specify Who/When/Where

Have you ever spoken to a counselor, social worker, psychologist, teacher, or any other adult because of a sexual experience you had?

Select an Option ▼

If yes, explain

Questions for Clinicians or Qualified Case Manager to Answer

Does the child or youth exhibit any gender nonconforming appearance or manner?

Select an Option ▼

If yes, explain

Does the child or youth have any current or past criminal charges?

Select an Option ▼

If yes, list the charges and explain

Save

Does the child or youth have any developmental disability or illness or suspected of having any of the above?

Select an Option

If yes, explain

Height

0

Weight

0

BMI

Other specific information that may indicate heightened needs and/or additional safety precaution:

Select an Option

If yes, explain

Does the child or youth have any mental disability or illness or suspected of having any of the above?

Select an Option

Does the child or youth have any physical disability or illness or suspected of having any of the above?

Select an Option

Save

OMB 0970-0553 [valid through MM/DD/YYYY]

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to allow ORR to reduce the risk that a child or youth is sexually abused or abuses someone else while in ORR custody. Public reporting burden for this collection of information is estimated to average 0.75 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.

UAC-S-9 [Rev. MM/DD/YYYY]

Assignments and Follow-Up Tab

Basic Information **Assignments And Follow-Up** Documents Certification

Housing, Other Service Assignments, and Follow-Up

Housing and Other Service Plan

The child or youth was placed in a room/dormitory that reflects the minor's preference

Select an Option ▼

If yes, explain

The child or youth was placed in educational or activities group(s) to reflect the minor's preference

Select an Option ▼

If yes, explain

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

Pending Submitted

Assessment Status: Pending

✓ Mark Assessment Status as Complete

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

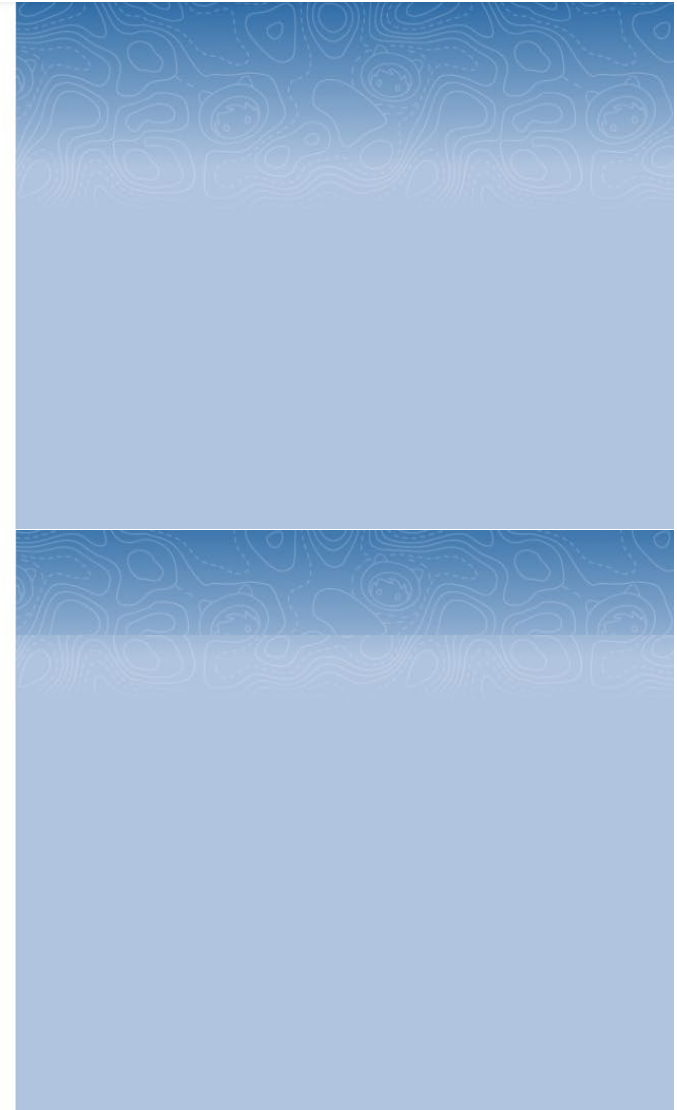
Date of Referral:

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

No specific action taken

Explain

Save

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Documents Tab

Basic Information Assignments And Follow-Up **Documents** Certification

 Case Management Documents (1)

Refresh

Add Documents

Title ↑	Original ... ▾	Record T... ▾	Other Do... ▾	Descripti... ▾	Date Rec... ▾	Created By ▾	Created ... ▾
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1

Pending

Submitted

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✓ Mark Assessment Status as Complete

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Documents Data Entry Window

Add File Details

Record Type

* Title Verified by Government Agency/ Consulate
 --None--

* Document Type --None-- Entry
 Search Entries...

Date Document Issued (if applicable) Individual
 Search Profiles...

Date Received Adult Contact Relationship
 Search Adult Contact Relationshi

Expiration Date

Description

File 1 of 1

Certification Tab

Admission - Clinician Certification

I confirm that I have completed all of the required sections and the information is accurate to the best of my knowledge.

Printed Name ⓘ

Title (Staff Title)

Save

System Information

Created By

Last Modified By

Pending Submitted

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