

Assessment for Risk

UAC Basic Information

First Name:

Last Name:

AKA:

Status:

Date of Birth:

A No.:

Age:

Child's Country of Birth:

Gender:

LOS:

Current Program:

Admitted Date:

Assessment for Risk

**INSTRUCTIONS: A care provider facility Clinician or Qualified Case Manager must complete the Assessment for Risk in the ORR database within 72 hours of a child or youth's admission. It must be updated every 30 days. The purpose of the assessment is to identify risk factors for potential sexual victimization or sexual abuser tendencies so early intervention can take place to mitigate any potential risks or safety concerns. Although the assessment presents a specific list of questions, the Clinician or Qualified Case Manager is expected to draw upon his/her professional training to obtain any additional information that may contribute to a thorough assessment. The assessment includes questions that the Clinician or Qualified Case Manager obtains from the child or youth as well as questions that the Clinician or Qualified Case Manager must answer based on his/her professional assessment of the individual case.**

Child's Primary Language:

Intake conducted in what language:

INFORMATION CLINICIANS OR QUALIFIED CASE MANAGERS OBTAIN FROM CHILD OR YOUTH

1. Do you feel safe in your current room assignment or the assignment that will be given to you?  
If No, explain:  Yes  No
  
2. Has anyone made any inappropriate comments to you about your body, clothes, or appearance that made you uncomfortable at this facility?  
If Yes, explain:  Yes  No
  
3. Do you identify as:
 

<input type="checkbox"/> Decline to Answer	<input checked="" type="checkbox"/> Straight
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Gay
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Questioning
<input type="checkbox"/> Intersex-Identify as Male	<input type="checkbox"/> Intersex-Identify as Female
<input type="checkbox"/> Transgender: If checked, choose one: <input type="radio"/> Male to Female <input type="radio"/> Female to Male <input type="radio"/> Other, Specify	
<input type="checkbox"/> Other, Specify:	
  
4. If the child or youth identified as Transgender or Intersex, Click Here:   
If you clicked the box, then answer the following:
  - (a) Ask whether the child or youth would rather be housed with boys or girls?:  
 Housed with Boys  Housed with Girls  No Preference
  - (b) Ask whether the child or youth would rather have a female or male staff member conduct a pat down search if one is necessary:  
 Male Staff  Female Staff  No Preference
  
5. Do you feel safe telling people about your sexual preference or gender identity since you have been here?  
If No, explain:  Yes  No  Decline to Answer
  
6. Is there something that you think we can do to help you feel safe and comfortable while you are here?  
If Yes, explain:  Yes  Not at this time
  
7. Do you find that people make a lot of sexual comments to you or about you? \*  
If Yes, explain:  Yes  No  Decline to Answer
  
8. Have you ever been sexually active?
 

Decline to Answer, Explain:

Yes. If yes, pick one:  With Males Only  With Females Only  With both Males and Females  Decline to Answer

No

Other, Specify:

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 0.5 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.

If you click Yes above, please ask the following: Have you ever had a sexual experience that was not consensual?  Yes  No  Decline to Answer  
Explain:

9. Have you ever felt like you needed to perform sexual favors or allow someone to touch your body in a sexual way in order to avoid additional harm, to obtain something you needed or wanted, or to be accepted by a person or group of people?  Yes  No  Decline to Answer  
If Yes, explain:

10. Have you ever spoken to a counselor, social worker, psychologist, teacher, or any other adult because of a sexual experience you had?  Yes  No  Decline to Answer  
If Yes, explain:

**INSTRUCTIONS: After interviewing the child or youth and reviewing relevant case files and other records, Clinicians and Qualified Case Managers must use their professional opinion to answer the following questions.**

**QUESTIONS FOR CLINICIANS OR QUALIFIED CASE MANAGERS TO ANSWER**

1. Does the child or youth exhibit any gender nonconforming appearance or manner?  Yes  No  
If Yes, explain:

2. Does the child or youth have any current or past criminal charges?  Yes  No  
If Yes, List the Charges and Explain:

3. Does the child or youth have any mental, physical, or developmental disability or illness or suspected of having any of the above?  
 No  
 Yes  Mental  Physical  Developmental  
Explain: n/a  
 Suspected  Mental  Physical  Developmental  
Explain: n/a

4. What is the child's physical size and stature?  Average  Smaller than Average  Larger than Average

5. Other specific information that may indicate heightened needs and/or additional safety precaution:  Yes  No  
If Yes, explain:

**INSTRUCTIONS: After completing the above assessment, determine if any housing and other service assignments are needed to ensure the safety and well-being of the child or youth. Describe housing and other service assignments here. Indicate specific actions and follow-up. If housing and other service assignments are changed at any time, including after the initial placement, describe the change and the reason for the change here.**

**HOUSING, OTHER SERVICE ASSIGNMENTS, AND FOLLOW-UP**

1. Housing and Other Service Plan

2. If the child or youth identified as Transgender or Intersex, Click Here:   
If you clicked the box, answer the following:  
(a) The child or youth was placed in a room/dormitory that reflects the minor's preference  Yes  No  
Explain:  
(b) The child or youth was placed in educational or activities group(s) to reflect the minor's preference  Yes  No  
Explain:

3. 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  
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:

Other Attachments

No specific action taken

Explain:

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Staff Signature:

Date/Time:

Staff Name:

Staff Title:

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Translator's Signature:

Date/Time:

Translator's Name:

Language: