

## Medical Assessment Form

### Unaccompanied Alien Children Bureau Office of Refugee Resettlement (ORR)

#### General Information

|   |   |   |      |   |                       |                     |
|---|---|---|------|---|-----------------------|---------------------|
| <b>Child</b>                                | Last name:  |   |      | First name:   |                       |                     |
|   | DOB:  | A#:   | Sex: | Date evaluated:                                     | Time evaluated:       |                     |
|   | Primary language:   | Who provided appropriate language services for child during evaluation? |      | • HCP fluent in child's primary language            | • Trained interpreter | • Not provided      |
| <b>Evaluating Healthcare Provider (HCP)</b> | Name: <span style="float: right;">MD / DO / PA / NP</span>  |   |      | Phone number:                                       |                       | Clinic or Practice: |
|   | Street address:   |   |      | City/Town:  |                       | State:              |
|   | Location where child received care (e.g., Primary health care provider/Pediatrician, medical specialist):   |   |      |   |                       |                     |
| <b>Program</b>                              | Program name:   |   |      | • Program Staff Member Present During Exam with HCP |                       |                     |
| <b>Reason for visit:</b>                    | • Initial medical exam (IME)*      • New complaint/concern      • Follow-up visit with PCP for previous complaint/concern<br>• Specialist visit, type: _____      • Routine well-child check/Establish care |   |      |   |                       |                     |

#### History and Assessment\*

##### Vital Signs

| Temperature (T) | Heart Rate (HR) | BP (≥ 3 yrs) | Resp Rate (RR) | Height (HT) | Weight (WT) | BMI (≥2 yrs) | BMI %ile |
|-----------------|-----------------|--------------|----------------|-------------|-------------|--------------|----------|
| °C              |                 |              |                | cm          | kg          |              |          |

**Allergies:**    ☐ No    ☐ Yes, specify below:

|          | Food | Medication | Environmental |
|----------|------|------------|---------------|
| Allergen |      |            |               |
| Reaction |      |            |               |

**Vision Screening (≥ 3 years):**    • Yes, specify below    • Not performed    **Hearing Screening:**    ☐ Yes, specify below    ☐ Not performed

|             | Right Eye | Left Eye | Both eyes | Final            | Hearing Screening                              | • Pass | • Fail |
|-------------|-----------|----------|-----------|------------------|--|--------|--------|
| Corrected   | 20 /      | 20 /     | 20 /      | • Pass    • Fail | OAE/ABR (Preferred for < 4 years)              | • Pass | • Fail |
| Uncorrected | 20 /      | 20 /     | 20 /      | • Pass    • Fail | Pure Tone Audiometry (Preferred for ≥ 4 years) | • Pass | • Fail |
|             |           |          |           |                  | Gross Hearing (Acceptable for all ages)        | • Pass | • Fail |

#### Medical & Mental Health History (including dates & locations of care)

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Chronic/Underlying conditions: \_\_\_\_\_

Family: \_\_\_\_\_

Healthcare received in DHS custody/during journey: \_\_\_\_\_

**Medications (dosage frequency & dates):**    • Past: \_\_\_\_\_

• Current: \_\_\_\_\_

#### Reproductive History (complete for anatomically female UC who have started menarche):

Date of LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_,    • Approximate    • Exact    • Contraceptive use, specify (e.g., IUD, pills): \_\_\_\_\_

Pregnancy history:    • No    • Yes, # of: vaginal deliveries \_\_\_\_, C-sections \_\_\_\_, miscarriages/abortions \_\_\_\_, ectopics \_\_\_\_, living children \_\_\_\_

Pregnancy/Postpartum complications: \_\_\_\_\_    • Currently breastfeeding

**History of abuse:**    • Yes, specify    • Denied, with no obvious signs    • Denied, but obvious signs present    • Unknown

Type(s):    • Verbal    • Emotional    • Physical, specify: \_\_\_\_\_

• Sexual (with or without penetration), estimated date of last encounter: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

• Other victimization (e.g., gang, bullying, crime): \_\_\_\_\_

**Consensual sexual activity (with penetration):**    • No    • Yes, estimated date of last encounter: \_\_\_\_ / \_\_\_\_ / \_\_\_\_    • Unknown

**Substance use:**    • Yes, specify    • Denied, with no obvious signs/symptoms    • Denied, but obvious signs/symptoms present    • Unknown

|                      | Alcohol | Tobacco/Nicotine | Marijuana | Injection drugs (IDU) | Other substances |
|----------------------|---------|------------------|-----------|-----------------------|------------------|
| Specify substance(s) |         |                  | N/A       |                       |                  |
| Frequency/Quantity   |         |                  |           |                       |                  |
| Date of last use     |         |                  |           |                       |                  |

**Travel history:** \_\_\_\_\_

#### Review of Systems (ROS) and Physical Exam\*

**Concerns expressed by child/caregiver:**    No    ☐ Yes, specify: \_\_\_\_\_

**Were any physical signs/symptoms reported by the child or observed by program staff or HCP?**

€ No € Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy):

| Sign/Symptom | • Pain, location: _____ | € Fever (>37.8 C°) or chills | € Red Eyes         | € Runny Nose     | € Sore Throat      | € Cough     | € Difficulty breathing/ Shortness of Breath |
|--------------|-------------------------|------------------------------|--------------------|------------------|--------------------|-------------|---|
| Onset Date   |                         |                              |                    |                  |                    |             |   |
| Sign/Symptom | € Nausea                | € Vomiting                   | € Diarrhea         | € Neck stiffness | • Headache         | € Dizziness | € Confusion/Altered mental status           |
| Onset Date   |                         |                              |                    |                  |                    |             |   |
| Sign/Symptom | € Neurologic symptoms   | € Skin lesions/Rash          | € Yellow skin/eyes | € Swollen glands | € Unusual bleeding | € Other:    | € Other:                                    |
| Onset Date   |                         |                              |                    |                  |                    |             |   |

**Physical Examination\***

| Systems                           | Normal findings  | Abnormal findings, specify or if not evaluated, give reason: |
|-----------------------------------|--|--|
| General                           | • Well-appearing/nourished; no distress; developmentally appropriate                 | •  |
| Head/Neck                         | • Normocephalic, neck supple; no adenopathy or masses                                | •  |
| Eyes                              | • PERRL, EOMI; no redness/discharge  | •  |
| ENT/Dental                        | • TMs WNL; no rhinorrhea; o/p w/o erythema, lesions, caries, abscess                 | •  |
| Cardiovascular                    | • Regular rate & rhythm; no murmurs; normal pulses; cap refill < 3 sec               | •  |
| Lungs                             | • Clear to auscultation, no wheezes, crackles, rhonchi, no accessory muscle use      | •  |
| Abdomen                           | • Non-distended; soft and non-tender; no masses or organomegaly                      | •  |
| Genitourinary                     | • External GU normal; Tanner ____: no lesions, discharge, hernia                     | •  |
| Musculoskeletal/ Back/Extremities | • Full range of motion of all extremities; no joint swelling, erythema; no scoliosis | •  |
| Neurologic                        | • Typical gait, strength, tone, sensation, speech & behavior for age                 | •  |
| Skin                              | • No rashes, lesions, jaundice, pallor, scars, birthmarks, or tattoos                | •  |

Other:

**Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?**

• No • Yes, specify below:

- Feels empty, hopeless, sad, numb more often than not
- Feels constantly worried, anxious, nervous more often than not
- Experiences mood swings, from very high to very low
- Relives traumatic events from the past
- Feels easily annoyed or irritated
- Feels afraid, easily startled, jumpy
- Has trouble concentrating, restless, too many thoughts
- Has trouble eating, sleeping
- Has nightmares
- Engages in self-harm
- Hears voices or sees things others do not see (hallucinations)
- Thoughts of hurting others
- Thoughts of hurting self, would be better dead
- Other concerns: \_\_\_\_\_

Is child able to attribute these feelings to a specific reason(s)? • No • Yes, specify: \_\_\_\_\_

**Laboratory Testing\***

| Condition                   | Indicators  | Test                               | Result  |
|-----------------------------|---|------------------------------------|---|
| CBC w/ diff                 | <6 yrs <u>at IME</u>  | • Blood/Serum                      | • Ordered • Pending; collected: ____/____/____  |
| Lead                        | <6 yrs, lactating or pregnancy <u>at IME</u>  | • Capillary, Lead                  | • Negative • Positive (≥3.5 µg/dL), level: ____ |
|                             |   | • Blood/Serum, Lead                | • Ordered • Pending; collected: ____/____/____  |
| Pregnancy                   | ≥10 yrs or <10 yrs who have reached menarche <u>at IME</u> , sexual activity/abuse/assault            | • Urine pregnancy                  | • Negative • Positive • Indeterminate           |
| HIV                         | All children <u>at IME</u>  | • Rapid, fingerstick/oral          | • Negative • Positive • Indeterminate           |
|                             |   | • Blood/Serum, 4 <sup>th</sup> Gen | • Ordered • Pending; collected: ____/____/____  |
| Syphilis                    | <2 yrs & not with biological mother <u>at IME</u> , sexual activity/abuse/assault                     | • RPR/VDRL                         | • Ordered • Pending; collected: ____/____/____  |
| Chlamydia                   | Sexual activity/abuse/assault   | • NAAT/PCR                         | • Ordered • Pending; collected: ____/____/____  |
| Gonorrhea                   | Sexual activity/abuse/assault   | • NAAT/PCR                         | • Ordered • Pending; collected: ____/____/____  |
| Hepatitis B                 | Pregnancy, sexual abuse/assault, IDU, country-based   | • Surface antigen                  | • Ordered • Pending; collected: ____/____/____  |
| Hepatitis C                 | Pregnancy, IDU  | • Total antibody                   | • Ordered • Pending; collected: ____/____/____  |
| COVID-19                    | <u>Any</u> COVID-19 symptom, incl. but not ltd. to runny nose, sore throat, cough, headache, diarrhea | Rapid: • Ag • PCR                  | • Negative • Positive • Indeterminate           |
|                             |   | • NAAT/PCR                         | • Ordered • Pending; collected: ____/____/____  |
| Influenza                   | Fever + cough or sore throat  | • Rapid flu                        | • Negative • Positive, type(s): • A • B • Unk   |
| Strep throat                | Sore throat + fever without cough, HCP discretion   | • Rapid strep                      | • Negative, • culture ordered • Positive        |
| Other Reportable Infectious | Specify: _____  |                                    | • Ordered • Pending; collected: ____/____/____  |

|                   |          |  |
|-------------------|----------|--|
| Disease (Non-TB): | Specify: | <input type="checkbox"/> Ordered <input type="checkbox"/> Pending; collected: ____/____/____ |
|-------------------|----------|--|

| TB Screening*  |   |   |  |   |
|--|---|---|--|---|
| Has child ever been exposed to a person with <b>active</b> TB disease? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____  |   |   |  |   |
| Has child ever been treated for TB? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify type & details: <input type="checkbox"/> Active TB disease <input type="checkbox"/> Latent TB infection (LTBI)   |   |   |  |   |
| TB screening indicator   | Test  |   | Result   |   |
| <2 yrs of age at IME   | • PPD/Tuberculin skin test (TST)  | <input type="checkbox"/> Ordered  | <input type="checkbox"/> Pending; date performed: ____/____/____, date read: ____/____/____; Result (mm): ____   |   |
| ≥2 yrs of age at IME   | TB blood test (IGRA):<br>• QuantiFERON® -TB Gold In-Tube test (QFT-GIT)<br><input type="checkbox"/> T-SPOT® .TB test (T-Spot)   | <input type="checkbox"/> Ordered  | <input type="checkbox"/> Pending; collected: ____/____/____  |   |
| ≥15 yrs of age at IME  | <input type="checkbox"/> Single view (PA) CXR   | <input type="checkbox"/> Ordered  | <input type="checkbox"/> Pending; performed: ____/____/____  |   |
| <15 yrs and + TST/IGRA or exposure/treatment history   | <input type="checkbox"/> 2-view (PA and lateral) CXR  | <input type="checkbox"/> Ordered  | <input type="checkbox"/> Pending; performed: ____/____/____  |   |
| <b>TB Screening Outcome:</b>   | <input type="checkbox"/> Pending <input type="checkbox"/> Negative for TB condition; No further follow up needed <input type="checkbox"/> TB, Latent (LTBI) <input type="checkbox"/> Referred to Health Department/ specialist for active TB evaluation <input type="checkbox"/> Not performed: _____                               |   |  |   |
| <b>If referred to HD/specialist, was an active TB work-up initiated?</b><br><input type="checkbox"/> No, specify reason: _____<br><input type="checkbox"/> Yes, specify reason: <input type="checkbox"/> Signs/Symptoms <input type="checkbox"/> Abnormal imaging <input type="checkbox"/> Exposure history <input type="checkbox"/> Initiation of LTBI treatment <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Specimen collected by HD/specialist:    Specimen type: _____    Tests ordered: _____ |   |   |  |   |
| Diagnosis and Plan*  |   |   |  |   |
| <b>Diagnosis:</b> Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If <b>Yes</b> , check all diagnoses that apply. Specify in the space provided, where indicated.  |   |   |  |   |
| General/Constitutional   | HEENT   | Respiratory/Pulmonary   | Cardiovascular   | Gastrointestinal  |
| <ul style="list-style-type: none"> <li>• Allergic reaction</li> <li>• Allergy: _____</li> <li>• Anemia</li> <li>• Dehydration</li> <li>• Developmental delay</li> <li>• Lead in blood</li> <li>• Fatigue</li> <li>• Lymphadenopathy</li> <li>• Obesity</li> <li>• Sickle cell disease</li> <li>• Underweight/Weight loss</li> <li>• Other: _____</li> </ul>  | <ul style="list-style-type: none"> <li>• Allergic rhinitis</li> <li>• Cerumen impaction</li> <li>• Conjunctivitis</li> <li>• Hearing issues: _____</li> <li>• Otitis externa</li> <li>• Otitis media</li> <li>• Pharyngitis, strep</li> <li>• Pharyngitis, other</li> <li>• Vision issues: _____</li> <li>• Other: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Abnormal CXR (Non-TB): _____</li> <li>• Asthma, severity: _____</li> <li>• Bronchiolitis</li> <li>• Chronic cough</li> <li>• Croup</li> <li>• Influenza, lab-confirmed</li> <li>• Influenza-like illness (ILI)</li> <li>• Pneumonia</li> <li>• Shortness of breath/wheezing</li> <li>• Upper respiratory illness</li> <li>• Other: _____</li> </ul>                            | <ul style="list-style-type: none"> <li>• Arrhythmia</li> <li>• Chest pain</li> <li>• Congenital heart disease: _____</li> <li>• High blood pressure</li> <li>• Heart murmur</li> <li>• Myocarditis/Pericarditis/Endocarditis</li> <li>• Syncope/Fainting</li> <li>• Other: _____</li> </ul>  | <ul style="list-style-type: none"> <li>• Abdominal pain</li> <li>• Appendicitis</li> <li>• Constipation</li> <li>• Diarrhea, acute/chronic</li> <li>• Failure to thrive</li> <li>• Gastritis/Peptic ulcer</li> <li>• Gastroenteritis</li> <li>• GI bleeding</li> <li>• Heartburn/Reflux</li> <li>• Inflammatory bowel disease</li> <li>• Intestinal parasites: _____</li> <li>• Jaundice</li> <li>• Liver disease</li> <li>• Nausea/Vomiting</li> <li>• Other: _____</li> </ul> |
| Dental   |   | Endocrine Disorder  |  |   |
| <ul style="list-style-type: none"> <li>• Broken tooth/teeth</li> <li>• Gingivitis/Gum disease</li> <li>• Impacted tooth/teeth</li> <li>• Infection/abscess</li> </ul>  |   | <ul style="list-style-type: none"> <li>• Missing tooth/teeth</li> <li>• Tooth decay/caries</li> <li>• Tooth sensitivity</li> <li>• Other: _____</li> <li>• Acanthosis nigricans</li> <li>• Delayed/Precocious puberty</li> <li>• Diabetes, Type 1 and 2</li> <li>• Hyper/Hypothyroidism</li> <li>• Short stature</li> <li>• Other: _____</li> </ul>   |  |   |
| Genito-urinary/Reproductive  |   | Musculoskeletal   | Potentially Reportable Infectious Disease  |   |
| <ul style="list-style-type: none"> <li>• Abnormal vaginal discharge</li> <li>• Abortion</li> <li>• Amenorrhea/Abnormal uterine bleeding</li> <li>• Bed-wetting</li> <li>• Childbirth</li> <li>• Consensual sexual activity</li> <li>• Genital lesions</li> <li>• Gynecomastia/Breast mass</li> <li>• Herpes simplex virus</li> <li>• Inguinal hernia</li> </ul>  |   | <ul style="list-style-type: none"> <li>• Kidney disease/stones</li> <li>• Menstrual cramping/pain</li> <li>• Miscarriage</li> <li>• Pelvic inflammatory disease</li> <li>• Pregnant, gestational age: ____ wks; est. due date: ____/____/____</li> <li>• Proteinuria/Hematuria</li> <li>• Sexual abuse/assault</li> <li>• Testicular pain/Torsion</li> <li>• Urinary tract infection</li> <li>• Other: _____</li> </ul> | <ul style="list-style-type: none"> <li>• Back pain</li> <li>• Bone tumors (benign/malignant)</li> <li>• Extremity/Joint pain</li> <li>• Fracture</li> <li>• Hematoma/Bruise</li> <li>• Ligamentous/Tendon injury</li> <li>• Myalgia</li> <li>• Scoliosis/Kyphosis</li> <li>• Sprain/Strain</li> <li>• Other: _____</li> </ul>      | <ul style="list-style-type: none"> <li>• Acute hepatitis A</li> <li>• Acute/chronic hepatitis B</li> <li>• Acute/chronic hepatitis C</li> <li>• Chikungunya</li> <li>• Chlamydia</li> <li>• COVID-19</li> <li>• Dengue</li> <li>• Gonorrhea</li> <li>• HIV</li> <li>• Malaria</li> <li>• Measles</li> <li>• Mumps</li> </ul>  |
|  |   |   | <ul style="list-style-type: none"> <li>• Pertussis</li> <li>• Rubella</li> <li>• Sepsis/Meningitis</li> <li>• Syphilis</li> <li>• TB, active disease</li> <li>• TB, latent (LTBI)</li> <li>• Typhoid fever</li> <li>• Varicella</li> <li>• Zika virus</li> <li>• Viral hemorrhagic fever: _____</li> <li>• Other: _____</li> </ul> |   |
| Neurological   |   | Skin, Hair, and Nails   |  |   |

|   |   |   |   |  |
|---|---|---|---|--|
| <ul style="list-style-type: none"><li>Brain tumor</li><li>Cerebral palsy</li><li>Cerebrovascular disease</li><li>Headache/Migraine</li><li>Seizure/Epilepsy</li></ul> | <ul style="list-style-type: none"><li>Traumatic brain injury/Concussion</li><li>Vertigo/Dizziness</li><li>Weakness</li><li>Other: _____</li></ul> | <ul style="list-style-type: none"><li>Acne</li><li>Atopic dermatitis/Eczema</li><li>Cellulitis/Abscess</li><li>Contact dermatitis</li><li>Diaper rash</li><li>Hair loss/Alopecia areata</li></ul> | <ul style="list-style-type: none"><li>Impetigo</li><li>Ingrown toenail</li><li>Lice</li><li>Onychomycosis</li><li>Scabies</li><li>Scars</li></ul> | <ul style="list-style-type: none"><li>Tattoos</li><li>Tinea pedis/corporis/cruris/capitis</li><li>Urticaria</li><li>Warts</li><li>Other: _____</li></ul> |
|---|---|---|---|--|

|  |  |  |   |
|--|--|--|---|
| <b>Behavioral and Mental Health Concerns</b> | <ul style="list-style-type: none"><li>Anxiety symptoms (e.g., panic attacks, excessive worry/fear)</li><li>Manic symptoms (e.g., elated mood, pressured speech)</li><li>Delusions</li><li>Urge for/current harm to others</li><li>Other: _____</li></ul> | <ul style="list-style-type: none"><li>Trauma symptoms (e.g., nightmares, flashbacks)</li><li>Social/Emotional delay</li><li>History of psychiatric diagnoses or treatment: _____</li></ul> | <ul style="list-style-type: none"><li>Depressive symptoms</li><li>Hallucinations</li><li>Urge for/current self-harm</li></ul> |
|--|--|--|---|

**Plan:** Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

|   |
|---|
| <input type="checkbox"/> Immunizations administered during visit                                      |
| <input type="checkbox"/> Immunizations documented on foreign record reviewed and validated            |
| <input type="checkbox"/> Immunizations indicated but not given; specify: _____                        |
| <input type="checkbox"/> Age-appropriate anticipatory guidance discussed and/or handout given         |
| <input type="checkbox"/> Child educated on healthcare services received and treatment recommendations |
| <input type="checkbox"/> Medications administered/prescribed:   |

| Medication Name | Reason | Date Started | Expected end date | Dose | Directions | Psychotropic? |
|-----------------|--------|--------------|-------------------|------|------------|---------------|
|                 |        |              |                   |      |            |               |
|                 |        |              |                   |      |            |               |
|                 |        |              |                   |      |            |               |

|   |
|---|
| <input type="checkbox"/> Child requires isolation for a communicable disease; specify diagnosis, start/end dates: _____   |
| <ul style="list-style-type: none"><li>Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:<ul style="list-style-type: none"><li><input type="checkbox"/> Onsite care provider clinician evaluation: _____</li><li><input type="checkbox"/> Increased level of supervision for mental health concern: _____</li><li><input type="checkbox"/> Assistance with daily living activities: _____</li><li><input type="checkbox"/> Durable medical equipment: _____</li><li><input type="checkbox"/> Physical activity restrictions: _____</li><li><input type="checkbox"/> Dietary restrictions: _____</li><li><input type="checkbox"/> Other: _____</li></ul></li><li>Child has/may have an ADA disability: _____</li><li>Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:<ul style="list-style-type: none"><li>Return to clinic: _____</li><li>Mental health specialist evaluation: _____</li><li>Medical specialist evaluation: _____</li><li>Physical/Occupational/Speech therapy: _____</li><li>Surgery/Procedure needed/performed: _____</li><li>Other, specify: _____</li></ul></li></ul> |

|                                 |  |
|---------------------------------|--|
| <b>Child cleared to travel:</b> | <ul style="list-style-type: none"><li>Yes, with no restrictions</li><li>Yes, with restrictions (e.g., ground travel, travel safety plan, travel length): _____</li><li>No, reason: _____</li></ul> |
|---------------------------------|--|

Recommendations from Healthcare Provider / Additional Information

|  |
|--|
|  |
|--|

|   |                      |
|---|----------------------|
| Healthcare Provider Signature: _____    | Date: ____/____/____ |
| Healthcare Provider Printed Name: _____ |                      |

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