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| **Mental Health Assessment Form**  **Unaccompanied Alien Children Bureau**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child** | | | | 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 | |
| **Evaluating Healthcare Provider (HCP)** | | | | Name:  **MD / DO / PA / NP / PhD / PsyD** | | | | | | | | | | | | | | | | | | | | | | | | Phone number: | | | | | | | | | | | | | | Clinic or Practice: | | | | | | | | | | | | | | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | City/Town: | | | | | | | | | | | | | | | | | | State: | | | | | |
| Location where child received care (e.g., Psychiatrist/Psychiatric NP or PA visit, Psychologist visit): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Program** | | | | Program name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | * Program Staff Member Present During Exam with HCP | | | | | | | | | | | | | | | | | | | | |
| **Reason for visit:** | | | | | | * Initial specialist visit | | | | | | | | | | * Follow-up specialist visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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** | | |
| 0C | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | cm | | | kg | | | | | | | | |  | | | | | | |  | | |
| **Allergies:** | | | * No | | | | | * Yes, specify below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **Food** | | | | | | | | | | | | | | | | | | | **Medication** | | | | | | | | | | | | | | | | | | | | | | **Environmental** | | | | | | | | | | | | | |
| Allergen | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Reaction | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Medical & Mental Health History (including dates & locations of care):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic/Underlying conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | * Currently breastfeeding | | | | | | | |
| **Abuse:** | * Yes, specify | | | | | | | | | | * Denied, with no obvious signs | | | | | | | | | | | | | * Denied, but obvious signs present | | | | | | | | | | | | | | | | | * Unknown | | | | | | | | | | | | | | | |
| * Verbal: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Emotional: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Physical: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Sexual: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Other victimization (e.g., gang, bullying, crime): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Substance use:** | | | | | * Yes, specify | | | | | | | * Denied, with no obvious signs/symptoms | | | | | | | | | | | | | | | | | | | | | | * Denied, but obvious signs/symptoms present | | | | | | | | | | | | | | | | | | * Unknown | | | | |
|  | | | | | | | | | | **Alcohol** | | | | | | | **Tobacco / Nicotine** | | | | | | | | | | | | | | **Marijuana** | | | | | | | | | **Injection drugs** | | | | | | | | | | **Other substances** | | | | | | |
| Specify substance(s) | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | N/A | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Frequency/Quantity | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Date of last use | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| **Review of Systems (ROS) and Mental Status Exam (MSE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | | | | | | | | | | | | | | * Engages in self-harm | | | | | | | | | | | | | | | | | | * Other: | | | | | | | | | | | |
| * Feels constantly worried, anxious, nervous more often than not | | | | | | | | | | | | | | | | | | | | | | | | | | * Feels easily annoyed or irritated | | | | | | | | | | | | | | | | | |
| * Has trouble concentrating, restless, too many thoughts | | | | | | | | | | | | | | | | | | | | | | | | | | * Relives traumatic events from the past | | | | | | | | | | | | | | | | | |
| * Experiences mood swings, from very high to very low | | | | | | | | | | | | | | | | | | | | | | | | | | * Feels afraid, easily startled, jumpy | | | | | | | | | | | | | | | | | |
| * Hears voices or sees things others do not see (hallucinations) | | | | | | | | | | | | | | | | | | | | | | | | | | * Thoughts of hurting self, would be better dead | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Has trouble eating, sleeping | | | | | | | | | | | | | | | | | | | | | | | | | | | * Thoughts of hurting others | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Has nightmares | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Can child attribute feelings to a specific reason(s)? | | | | | | | | | | | | | | | | | | * No | | | | * Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Brief Mental Status Exam (MSE)** | | | | |
|  | **Normal** | | | **Abnormal, specify:** |
| Appearance | * Normal grooming & hygiene | | |  |
| Attitude | * Calm & cooperative | | |  |
| Behavior | * No unusual movements or psychomotor changes | | |  |
| Speech | * Normal rate/tone/volume without pressure | | |  |
| Affect | * Reactive & mood congruent; good range | | |  |
| Mood | * Euthymic | | |  |
| Thought processes | * Goal-directed & logical | | |  |
| Thought content | * Not passive/active suicidal/homicidal | | |  |
| Perception | * No hallucinations or delusions during interview | | |  |
| Orientation | * Oriented time/place/person/ self | | |  |
| Memory/ Concentration | * Short and long term intact | | |  |
| Insight/Judgement | * Good | * Fair | * Poor | |

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|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis and Plan** | | | | | | | | | | |
| **Diagnosis:** Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: | | | | | | | | | * No | * Yes |
| If **Yes**, check all diagnoses that apply. Specify in the space provided, where indicated. | | | | | | | | | | |
| **DSM:** | * Acute stress disorder/PTSD | | | | * ADHD | | * Adjustment disorder | * Autism | * Bipolar disorder | |
| * Conduct disorder | | | * Eating disorder | | * Generalized anxiety disorder | | | * Major depressive disorder | | |
| * Oppositional defiant disorder | | | | * Panic disorder | | * Primary psychotic disorder | | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Medical:** |  | | | | | | | | | |
|  | | | | | | | | | | |
| **Plan:** Check all that apply and specify where indicated. Please provide copies of office notes and lab/imaging results to program staff. | | | | | | | | | | |
| * Age-appropriate anticipatory guidance discussed and/or handout given | | | | | | | | | | |
| * Child educated on healthcare services received and treatment recommendations | | | | | | | | | | |
| * Labs/imaging ordered/performed | | | | | | | | | | |
| * Medications administered/prescribed:  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Medication Name | Reason | Date Started | Expected end date | Dose | Directions | Psychotropic | | |  |  |  |  |  |  | * No | * Yes | |  |  |  |  |  |  | * No | * Yes | |  |  |  |  |  |  | * No | * Yes | | | | | | | | | | | |
| * Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency: | | | | | | | | | | |
| * Onsite care provider clinician evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Increased level of supervision for mental health concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Placement at a residential treatment center (RTC)[[1]](#footnote-2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Assistance with daily living activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Child has/may have an ADA disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Child has health concerns that require follow-up services; specify needs and time frame by when services should occur: | | | | | | | | | | |
| * Return clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Mental health specialist evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| * Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Child cleared to travel:** | | * Yes, with no restrictions | | | | | | | | |
| * Yes, with restrictions (e.g., ground travel, travel safety plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * No, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Recommendations from Healthcare Provider / Additional Information** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Recommendations from Healthcare Provider / Additional Information** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_**  **Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |

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1. Requires the recommendation of a psychiatrist or clinical psychologist [↑](#footnote-ref-2)