

## UAC Basic Information



First Name:	<i>Auto-populated</i>	AKA:	<i>Auto-populated</i>
Last Name:	<i>Auto-populated</i>	Status:	<i>System-generated</i>
Date of Birth:	<i>Auto-populated</i>	Admitted Date:	<i>System-generated</i>
A#:	<i>Auto-populated</i>	Length of Stay:	<i>System-generated</i>
Country of Birth:	<i>Auto-populated</i>	Current Program:	<i>Auto-populated</i>
Sex:	<i>Auto-populated (options for male and female only)</i>	Portal ID:	<i>System-generated</i>
		Physical Location of Child:	<i>Auto-populated from UAC Portal Discharge Tab</i>

See UAC Policy Guide Section 4 and 5 for related policies.

## Child-Level Event Information

Select Different Event

Location of Event:	<i>Auto-populated</i>	Specific Program:	<i>Auto-populated</i>	Specific Location:	<i>Auto-populated</i>
Date of Event:	<i>Auto-populated</i>	Time of Event:	<i>Auto-populated</i>	Event ID:	<i>System-generated</i>
Date Care Provider Became Aware of Event:	<i>Auto-populated</i>	Time Care Provider Became Aware of Event:	<i>Auto-populated</i>		
Short Synopsis:	<i>Auto-populated</i>				

## Child-Level Event

☒ Emergency SIR

☐ Non-Emergency SIR

☐ Behavioral Note

☐ Historical Disclosure

Report Status:\* ☐ Open ☐ Closed

Date Report Opened:

Date Report Closed:

Emergency SIR Category (Select all that apply)



Category Definitions & Examples

☐ Death of a UAC

<input type="checkbox"/> Incident Involving Weapons	<input type="checkbox"/> Possession <input type="checkbox"/> Use	
<input type="checkbox"/> Medical Emergency	<input type="checkbox"/> Acute illness <input type="checkbox"/> Exacerbation of a chronic medical condition <input type="checkbox"/> Injury or misadventure <input type="checkbox"/> Pregnancy-related <input type="checkbox"/> Psychiatric admission <input type="checkbox"/> Severe abuse/neglect	<input type="checkbox"/> Severe medical error <input type="checkbox"/> Severe mental health symptoms, without self-harm <input type="checkbox"/> Severe self-harm <input type="checkbox"/> Substance use <input type="checkbox"/> Suicidal ideation with a plan
<input type="checkbox"/> Sexual Abuse of Child by Adult	<input type="checkbox"/> Actual or simulated sexual intercourse <input type="checkbox"/> Any display of staff's uncovered buttocks, breast, or genitalia in the presence of a child <input type="checkbox"/> Forcing a child to engage in sexual exploitation of another child <input type="checkbox"/> Molestation (intentional penetration or touching unrelated to official job duties of a child's genitalia, anus, groin, breast, inner thigh, buttocks, or mouth by a body part or object, including kissing, with intent to abuse, arouse, or gratify sexual desire)	<input type="checkbox"/> Bestiality <input type="checkbox"/> Masturbation <input type="checkbox"/> Possession or use of child or adult pornography <input type="checkbox"/> Prostitution of a child <input type="checkbox"/> Sadistic or masochistic abuse <input type="checkbox"/> Voyeurism <input type="checkbox"/> Any attempt, threat, or request to engage in any of the activities above
<input type="checkbox"/> Sexual Abuse of Child by Child	<input type="checkbox"/> Bestiality <input type="checkbox"/> Child prostitution <input type="checkbox"/> Exposure of buttocks, breast, or genitalia of self or another person (excluding unintentional, incidental exposure such as in a bathroom) <input type="checkbox"/> Forcing a child to touch/penetrate genitalia, anus, groin, breast, inner thigh, or the buttocks of themselves or another child. <input type="checkbox"/> Intentional touching, directly or through the clothing, of another's genitalia, anus, groin, breast, inner thigh, or the buttocks	<input type="checkbox"/> Knowingly masturbating in another person's presence <input type="checkbox"/> Penetration of another child's anal, oral, or genital area by a body part or object <input type="checkbox"/> Possession or use of child pornography <input type="checkbox"/> Sadistic or masochistic abuse
<input type="checkbox"/> Unauthorized Absence		

## Individuals Involved

### Type of allegation\*

*Appears if user selects Sexual Abuse of Child by Adult or Sexual Abuse of Child by Child*

--Select--

[Staff and UAC](#)  
[UAC and UAC nonconsensual](#)  
[Non-Staff Adult and UAC](#)  
[Non-UAC Child and UAC](#)  
[Other](#)

Did someone other than this child initially reported the incident? ☐ Yes ☐ No

>| Add New Row

Name	Type	A#	Title	Specify
	<div>--Select--</div> <div>UAC</div> <div>Staff</div> <div>Non-UAC Child</div> <div>Non-Staff Adult</div>	Appears if user selects UAC	Appears if user selects Staff	Appears if user selects Non-UAC Child or Non-Staff Adult

How was this child involved?\*

--Select--

<multi-select dropdown>

Impacted

Exhibiting

Witness

Reporter

Other

Were other UAC involved? ☐ Yes ☐ No

>| Add New Row

Name	A #	Role	Specify
		<div>--Select--</div> <div>&lt;multi-select dropdown&gt;</div> <div>Impacted</div> <div>Exhibiting</div> <div>Witness</div> <div>Reporter</div> <div>Other</div>	

Were staff present or involved in the incident? ☐ Yes ☐ No

>| Add New Row

Name	Title	Role	Specify	Disciplinary Action for Staff
		<div>--Select--</div> <div>&lt;multi-select dropdown&gt;</div>		<div>--Select--</div> <div>&lt;multi-select dropdown&gt;</div>

		<i>Alleged Victim</i> <i>Alleged Perpetrator</i> <i>Witness</i> <i>Reporter</i> <i>Other</i>		<i>Suspended</i> <i>Terminated</i> <i>Reinstated</i> <i>Retrained</i> <i>Resigned</i> <i>N/A</i>
--	--	--	--	---

## Incident Information:

Full Description of Incident:\*

Was the child or anyone else injured?: \*

☐ Yes ☐ No

Specify:

## Actions Taken:

Was or will the child be referred to the local legal service provider for a follow-up legal consultation? \*

☐ Yes ☐ No

Was or will the child be referred for appointment of a child advocate? \*

☐ Yes ☐ No ☐ N/A (child already has a child advocate)

Was the child hospitalized and/or receive serious medical services? \*

☐ Yes ☐ No

*Appears if user selects Medical Emergency category*

Was or will the child be referred for healthcare services? \*

☐ Yes ☐ No

Specify Type(s) of Healthcare Services: \*

☐ Medical

☐ Mental Health/Behavioral

☐ Dental

*Appears if user selects "Yes"*

Describe the healthcare services that were or will be provided: \*

*Appears if user selects "Yes"*

Staff Response and Intervention:\*

Actions Taken for Impacted Child:\*

*(Field only appears if user selects Sexual Abuse of Child by Adult or Sexual Abuse of Child by Child)*

Actions Taken for Exhibiting Child or Alleged Adult Perpetrator:\*

*(Field only appears if user selects Sexual Abuse of Child by Adult or Sexual Abuse of Child by Child)*

Actions Taken for Witnesses:\*

(Field only appears if user selects Sexual Abuse of Child by Adult or Sexual Abuse of Child by Child)

Follow-up and/or Resolution:

(Field only appears if user DOES NOT select Sexual Abuse of Child by Adult or Sexual Abuse of Child by Child)

ORR Recommendations:

Immediate Phone Call Notifications:

>| Add New Row

Title	Name	Date Notified	Time Notified
9-1-1			
FFS Supervisor			
FFS			
Intakes Hotline	202-401-5709		
ICE FOJC <i>Appears if user selects Unauthorized Absence category</i>			
NCMEC <i>Appears if user selects Unauthorized Absence category</i>	1-800-843-5678		

Reporting: (Additional fields for each section only appear when the use selects Yes for the first question)

Was it reported to State  
Licensing?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

--Select--

Was the incident investigated  
by State Licensing?

Yes  
No  
To Be Determined  
Unknown

Date Notified the  
Incident will be  
investigated:

Case/Confirmation  
Number:

Explain

Disposition of Investigation:

--Select--

Substantiated  
Indicated  
Not Substantiated  
Unfounded  
Administratively Closed

Result/Findings of  
Investigation:

Attach Reports/Findings:

 Select File

>| Upload

>| Reset

File Name	File Size	File Type	Uploaded By	Uploaded Time	
					X

Was it reported to CPS?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Was the incident investigated  
by CPS?

--Select--

Yes  
No  
To Be Determined  
Unknown

Date Notified the  
Incident will be  
investigated:

Case/Confirmation  
Number:

Explain

Disposition of Investigation:

--Select--

Substantiated  
Indicated  
Not Substantiated  
Unfounded  
Administratively Closed

Result/Findings of  
Investigation:

Attach Reports/Findings:

 Select File

>| Upload

>| Reset

File Name	File Size	File Type	Uploaded By	Uploaded Time	
					X

Was it reported to Local Law Enforcement?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Officer Name:

Officer Badge:

Was the incident investigated by Local Law Enforcement?

Yes

No

To Be Determined

Unknown

Date Notified the Incident will be investigated:

Case/Confirmation Number:

Explain

Disposition of Investigation:

Substantiated

Indicated

Not Substantiated

Unfounded

Administratively Closed

Result/Findings of Investigation:

Attach Reports/Findings:

Select File

>| Upload

>| Reset

File Name	File Size	File Type	Uploaded By	Uploaded Time	
					X

Was it reported to DCPI?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Was the Incident Investigated by DCPI?

Yes

No

Date Notified the Incident will be investigated:

Case/Confirmation Number:

To Be Determined  
Unknown

Explain

Disposition of Investigation:

--Select--

Substantiated Tier I  
Substantiated Tier II  
Not Substantiated  
Unfounded  
Administratively Closed

Was it reported to DOJ/FBI?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Explain

Was it reported to OIG?\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Explain

Was it reported to DHS\*

☐ Yes ☐ No

Date of Report:

Time of Report:

Explain

Was it reported to Office on  
Trafficking in Persons  
(Shepherd)?\*

☐ Yes ☐ No

Date of Report:

Outcome of Report:

--Select--

Eligibility  
Interim Assistance  
Denial

Explain

Is an Incident Review form  
required? \*

☐ Yes ☐ No

Date Form  
Due:

Attach Incident Review form:

Select File

>| Upload

>| Reset



File Name	File Size	File Type	Uploaded By	Uploaded Time	
					X

#### ORR Notifications: \*

>| Add New Row

Title	Name	Date Notified	Time Notified	Method of Notification	Specify
FFS				--Select-- Phone call In-person Email Messaging app Mail Other	
FFS Supervisor				--Select--	
Field Manager				--Select--	
On-Call Field Staff	FieldOnCall@acf.hhs.gov			Email	
PO				--Select--	
Case Coordinator				--Select--	
CFS				--Select--	
SIR Triage	SIRTriage@acf.hhs.gov			Email	
DHUAC	DHUAC@acf.hhs.gov			--Select--	
				--Select--	

#### Other Notifications: \*

>| Add New Row

Title	Name	Date Notified	Time Notified	Method of Notification	Specify
Attorney of Record/Legal Service Provider				--Select-- Phone call In-person Email Messaging app Mail Other	
Parent/Legal Guardian				--Select--	

Child Advocate (if applicable)				--Select-- ▼	
Sponsor <i>Appears if user selects "yes" to question above on hospitalization or serious medical services</i>				--Select-- ▼	
Other Next-of-Kin (if applicable) <i>Appears if user selects Death of a UAC category</i>				--Select-- ▼	
Consulate <i>Appears if user selects Death of a UAC category</i>				--Select-- ▼	
ICE FOJC <i>Appears if user selects Unauthorized Absence or Death of a UAC category</i>				--Select-- ▼	
DHS ERO JFRMU <i>Appears if user selects Death of a UAC category</i>				--Select-- ▼	

**Reporter and Follow-Up Contact:\***

>| Add New Row

Type	Name	Title	Email	Telephone Number
Staff Filing Report				
Contact for Follow-Up				

>| Save

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to allow ORR care provider programs to inform ORR of urgent situations where there is an immediate threat to a child's safety and well-being that requires instantaneous action that occur while the child is in ORR custody. Public reporting burden for this collection of information is estimated to average 1.5 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. The OMB control number is 0970-XXXX and the expiration date is MM/DD/YYYY. If you have any comments on this collection of information please contact UACPolicy@acf.hhs.gov.