DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Refugee Resettlement

OMB No. 0970-0034
Exp. 11/30/2026

Name of Youth			Alien Registration No.	HHS Tracking No.
Last	*First*	*Middle*		

ORR-4 REPORT FORM
UNACCOMPANIED REFUGEE MINORS (URM) PROGRAM
OUTCOMES REPORT

State/ URD Agency	
Agency Name:	
Address:	
City:	
State:	Zip:

Provider Agency	
Agency Name:	
Address:	
City:	
State:	Zip:

Section I: Report Action

☐ *1. Annual Outcomes Report*
☐ *2. Follow-up Annual Report:* Former URM clients who are 17 to 21 years old and have terminated all ORR-funded services. Proceed to Section VI. Outcomes.

Date data was collected	*(mm/dd/yyyy)*
Age	

Section II: Identifying Data

1. Date of Birth

2. Sex ☐ *Female* ☐ *ale*

Section III: Education and Personal Functioning of the Youth

1. Education Information:

a. Most Recent Education and Grade Level, if applicable

☐ *Regular Mainstream School*
- ☐ *Less than 6th grade*
- ☐ *6th grade*
- ☐ *7th grade*
- ☐ *8th grade*
- ☐ *9th grade*
- ☐ *10th grade*
- ☐ *11th grade*
- ☐ *12th grade*

☐ *Alternative to High School*
- ☐ *9th grade*
- ☐ *10th grade*
- ☐ *11th grade*
- ☐ *12th grade*
- ☐ *Dual-credit program*
- ☐ *No Grade Assigned*

☐ *GED program*
☐ *Trade/Vocational program*
☐ *Job Corps/Job Corps equivalent*
☐ *Post-secondary education*
☐ *Not in school*

Provide additional information.

b. Youth is receiving English Language Learner (ELL) support. ☐ *Yes* ☐ *No*

2. Caseworker/Provider Assessment:

Assess the youth's functioning in the following areas at an age-appropriate level on a scale of 1 through 5, as indicated below. Provide an explanation if necessary.

	Poor	Below Average	Average	Above Average	Excellent	Explain
English Language Skill	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Education (other than English)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Social Adjustment	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Health Condition	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Mental Health	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Preservation of Ethnic and Religious Heritage	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Readiness to Live Independently	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	

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Section IV: Family Reunification

1. The youth has a permanency plan. ☐ *Yes* ☐ *No*

a. The youth's most recent primary permanency goal was:

☐ *Adoption* ☐ *Guardianship* ☐ *Reunification*
☐ *Another Planned Permanent Living Arrangement (APPLA)*
☐ *Permanent Placement with Fit and Willing Relative (PPFWR)*

2. Family reunification efforts in the reporting period

a. Parents or relatives in the U.S. have been (re-)assessed for reunification. ☐ *Yes* ☐ *No*

b. There have been significant developments in reunification efforts. ☐ *Yes* ☐ *No*

If Yes, describe efforts and significant developments:

c. There has been a decision to not reunify the youth with a parent or relative. ☐ *Yes* ☐ *No*

If Yes, explain any such decisions; include relationship(s) and reason(s) for not reunifying youth.

3. There have been family tracing efforts with parents or relatives in other countries for the purpose of reunification.

☐ *Yes* ☐ *No*

If Yes, describe family tracing efforts.

Section V: Transition to Adulthood Services

1. Youth's residence:

Address:

City: State: Zip:

2. Service Type(s):	*Yes*	*No*
a. Youth remains in foster care	☐	☐
b. Post-adjudication juvenile probation	☐	☐
c. Special education	☐	☐
d. Independent living needs assessment	☐	☐
e. Academic support	☐	☐
f. Post-secondary educational support	☐	☐
g. Career preparation	☐	☐
h. Employment programs/vocational training	☐	☐
i. Budget & financial management	☐	☐
j. Housing education & home management training	☐	☐
k. Health education & risk prevention	☐	☐
l. Family support & healthy marriage education	☐	☐
m. Mentoring	☐	☐
n. Supervised independent living	☐	☐
o. Room & board financial assistance	☐	☐
p. Education financial assistance	☐	☐
q. Other financial assistance *Type:*	☐	☐

Section VI: Outcomes

1. Outcomes reporting status:

☐ *a. Youth participated*
☐ *b. Youth declined*
☐ *c. Incapacitated*
☐ *d. Incarcerated*
☐ *e. Runaway/missing*
☐ *f. Unable to locate or invite*
☐ *g. Death*

2. Date of outcome data collection: (mm/dd/yyyy)

Data Elements	Queries	Responses			
		Yes	*No*	*Declined*	*Don't Know*
3. Foster care status	*Youth remains in foster care*	☐	☐		
4. Current full-time employment	*Are you currently employed full-time?*	☐	☐	☐	
5. Current part-time employment	*Are you currently employed part-time?*	☐	☐	☐	
6. Employment-related skills	*In the past year, did you complete an apprenticeship, internship or other on the job training, either paid or unpaid?*	☐	☐	☐	
7. Social Security	*Are you currently receiving SSI, Disability or other dependents' payments?*	☐	☐	☐	
8. Educational aid	*Are you currently using a scholarship, grant, stipend, student loan, voucher or other education financial aid to cover educational expenses?*	☐	☐	☐	

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PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: Through this information collection, the Administration for Children and Families (ACF) is gathering data on youth served through the Unaccompanied Refugee Minors Program including their location, status, and progress. Public reporting burden for this collection of information is estimated to average .5 hours for respondents from state agencies, 1 hour for respondents from provider agencies, and .5 hours for youth participants, 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 (8 U.S.C. 1522(d)). 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 Office of Management and Budget (OMB) control number. The OMB # is 0970-0034 and the expiration date is 11/30/2026. If you have any comments on this collection of information, please contact Anne Mullooly at Anne.Mullooly@acf.hhs.gov.

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9. Public financial assistance	*Are you currently receiving ongoing welfare [State TANF] payments to support your basic needs?*	☐	☐	☐		
10. Public food assistance	*Are you currently receiving public food assistance [SNAP or community program]?*	☐	☐	☐		
11. Public housing assistance	*Are you currently receiving any sort of public housing assistance?*	☐	☐	☐		
12. Other financial support	*Are you currently receiving any periodic and/or significant financial resources or support from another source not previously indicated and excluding paid employment?*	☐	☐	☐		
13. Highest educational certification received	*What is the highest educational degree or certification that you have received?*	☐	*a. GED*			
		☐	*b. high school diploma*			
		☐	*c. vocational certificate*			
		☐	*d. vocational license*			
		☐	*e. associate's degree*			
		☐	*f. bachelor's degree*			
		☐	*g. higher degree*			
		☐	*h. none of the above*			
		☐	*i. declined*			
14. Current enrollment and attendance	*Are you currently enrolled in and attending high school, GED classes, post-high school vocational training or college?*	☐	☐	☐		
15. Connection to adult	*Is there currently at least one adult in your life, other than your caseworker to whom you can go for advice or emotional support?*	☐	☐	☐		
16. Homelessness	*Have you ever been homeless at any time?*	☐	☐	☐		
17. Substance abuse referral	*Have you ever referred yourself or has someone else referred you for an alcohol or drug abuse assessment or counseling?*	☐	☐	☐		
18. Incarceration	*Have you ever been confined in a jail or other correctional facility or juvenile detention in connection with allegedly committing a crime?*	☐	☐	☐		
19. Children	*Have you ever given birth or fathered any children that were born?*	☐	☐	☐		
20. Marriage at child's birth	*If yes, were you married to the child's other parent at the time?*	☐	☐	☐		
21. Medicaid	*Are you currently on Medicaid [or use the name of the State's medical assistance program under title XIX]?*	☐	☐	☐	☐	
22. Other health insurance coverage	*Do you currently have health insurance other than Medicaid?*	☐	☐	☐	☐	
23. Health insurance type: Medical	*Does your health insurance include coverage for medical services?*	☐	☐	☐	☐	
24. Health insurance type: Mental health	*Does your health insurance include coverage for mental health services?*	☐	☐	☐	☐	
25. Health insurance type: Prescription drugs	*Does your health insurance include coverage for prescription drugs?*	☐	☐	☐	☐	
26. Health insurance type: Other	*Does your health insurance include coverage for other services, e.g., dental or vision*	☐	☐	☐	☐	
	Other type of coverage:					

Section VII: Report Submission Authority

1. Provider Agency

Agency Name:
Address:
City: State: Zip Code:

User Name:	*Title:*	*Date: (mm/dd/yyyy)*
Phone:	*Email:*	

Secondary contact:	*Title:*
Phone:	*Email:*

2. State/ URD Agency

Agency Name:
Address:
City: State: Zip Code:

User Name:	*Title*	*Date: (mm/dd/yyyy)*
Phone:	*Email:*	

3. ORR

Name:	*Title:*	*ORR Approval Date:*
		(mm/dd/yyyy)

Approval/Denial Comments History:

In immediate response to priorities of the current administration, this form has been updated with the following changes prior to approval by the Office of Management and Budget (OMB), as required by the Paperwork Reduction Act (PRA) of 1995 (44. USC. 3501 et seq.). The PRA requires that agencies obtain OMB approval before requesting information from the public, and OMB review and approval for most changes to an approved information. ACF is working to process these changes through OMB to come into compliance with the PRA but has implemented changes to the OMB-approved form to ensure compliance with the following Executive Orders: Executive Order(s) 14168 and/or 14151, 14173, 14224

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PRA but has implemented changes to the OMB approved form to ensure compliance with the following Executive Orders: Executive Order(s) 14168 and/or 14151, 14173, 14224.
Other than these changes, this form is approved under OMB #: 0970-0034.