Administration for Children and Families

Office of Refugee Resettlement

Initial Assessment (Form S-8)

UAC Portal Version

UAC Basic Information

	**Last Name**	AUTP POPULATE	**Status:**	AUTO POPULATE
	Date of Birth:	AUTO POPULATE (MM/DD/YYYY)	**Admitted Date:**	AUTO POPULATE
	Age:	SYSTEM GENERATED	**LOS:**	SYSTEM GENERATED
	A No.:	AUTO POPULATE	**Current Program:**	AUTO POPULATE
	Country of Birth:	AUTO POPULATED	**Portal ID:**	AUTO POPULATE
	Sex:	AUTO POPULATE < Male, Female >	**Current Location of the Child:**	AUTO-POPULATE *(Source: UAC Portal Discharge Tab)*

Initial Intakes Assessment

INSTRUCTIONS: a staff member trained in the use of this form must complete it within 24 hours of the child or youth's admission at the care provider facility per UAC Policy Guide Sec. 3.2.1 – Admissions for Unaccompanied Alien Children. The staff member completing this form must be trained to ask and gather sensitive information in a child-friendly and culturally appropriate manner. This assessment will gather basic identifying information, identify immediate medical or mental health needs the child or youth has, ensure that the needs are appropriately met, and inform the child or youth's initial housing/ bed assignment.

Child's Arrival Date/ Time:	(Open Text) MM/DD/YYYY	(Open Text) HH:MM AM/ PM	**Intake Interview Date/ Time:**	(Open Text) MM/DD/YYYY	(Open Text) HH:MM AM/ PM
Preferred Language:	**<Dropdown Menu>** (-Select Language- *See Reference Table 1 – Language*)				
Intake Conducted in:	**<Dropdown Menu>** (-Select Language- *See Reference Table 1 – Language*)				
Other Languages Spoken	**Language**			**Fluency**	**Options**
	<Dropdown Menu> (-Select Language- *See Reference Table 1 – Language*)			**<Dropdown Menu>** (-Select One- *Fluent; Conversational; Novice*)	**>| Save**
Was the child able to clearly comprehend the questions?				☐ **Yes** ☐ **No**	
Date of departure from home country:	(Open Text) MM/DD/YYYY		**Date of Arrival in U.S. (approx.)**	(Open Text) MM/DD/YYYY	
Child's Eye Color:	**<Dropdown Menu>** (-Select Eye Color- *Brown; Black; Hazel; Blue; Green; Gray; Pink; Maroon; Dichromatic; N/A*)				

Family Information					**>| Add New Row**
Do you know anybody in the U.S.? Include relative and non-relative contacts in this section.	**Name**	**Relationship**	**Address**	**Phone**	**Potential Sponsor?**
	(Open Text)	**<Dropdown Menu>** (-Select Relationship- *See Reference Table 2 – "Relationship")*	*(Open Text)*	*(Open Text)*	☐ **Yes** ☐ **No** ☐ **Unknown**
	(Open Text)	**<Dropdown Menu>** (-Select Relationship- *See Reference Table 2 – "Relationship")*	*(Open Text)*	*(Open Text)*	☐ **Yes** ☐ **No** ☐ **Unknown**
	(Open Text)	**<Dropdown Menu>** (-Select Relationship- *See Reference Table 2 – "Relationship")*	*(Open Text)*	*(Open Text)*	☐ **Yes** ☐ **No** ☐ **Unknown**

	(Open Text)	**<Dropdown Menu>** (-Select Relationship- *See Reference Table 2 – "Relationship")*	*(Open Text)*	*(Open Text)*	☐ **Yes** ☐ **No** ☐ **Unknown**
Is there someone we can contact to let them know you are here?	(Open Text)				

Medical			
If any observed or reported medical concerns are checked in the section below, please immediately report these to the Clinician, Lead Case Manager, Program Director, Shift Supervisor, and/ or any on-call medical staff member for further guidance on the need to seek immediate medical care.			
Have you experienced any physical/ medical problems today or in the last 30 days?	☐ **Yes** ☐ **No**	**If Yes, please explain:**	(Open Text)
Have you experienced any physical/ medical problems?	☐ **Yes** ☐ **No**	**If Yes, please explain:**	(Open Text)
Do you have any allergies?	☐ **Yes** ☐ **No**	**If Yes, please explain:**	(Open Text)
Do you have any special dietary needs?	☐ **Yes** ☐ **No**	**If Yes, please explain:**	(Open Text)
Are you currently taking any prescribed or other medication?	☐ **Yes** ☐ **No**	**If Yes, list below. Other medication may include herbal remedies, over the counter remedies, etc.**	(Open Text)

Medication	**>| Add New Row**

Medication	Dose	Purpose
(Open Text)	(Open Text)	(Open Text)
(Open Text)	(Open Text)	(Open Text)

Observable or reported medical concerns (Check all that apply).		
Concern	Yes/ No	
Coughing	☐ **Yes** ☐ **No**	
Difficulty Breathing	☐ **Yes** ☐ **No**	
Dehydration	☐ **Yes** ☐ **No**	
Dizziness	☐ **Yes** ☐ **No**	
Confusion	☐ **Yes** ☐ **No**	
Fever	☐ **Yes** ☐ **No**	
Pregnant	☐ **Yes** ☐ **No**	
Exhaustion	☐ **Yes** ☐ **No**	
Lice	☐ **Yes** ☐ **No**	
Injuries	☐ **Yes** ☐ **No**	
Bruises	☐ **Yes** ☐ **No**	

Scabies	☐ Yes ☐ No		
Vomiting	☐ Yes ☐ No		
Abdominal Pain	☐ Yes ☐ No		
Coughing Blood	☐ Yes ☐ No		
Nausea	☐ Yes ☐ No		
Skin lesions/ rash	☐ Yes ☐ No		
Severe/ persistent headache	☐ Yes ☐ No		
Jaundice (Yellowing of the skin/ whites of the eyes)	☐ Yes ☐ No		
Neurological symptoms (Spasms, tics, uncontrollable movements, paralysis or numbness of any part of the body)	☐ Yes ☐ No		
Others (list)	☐ Yes ☐ No	**If yes: Specify:**	(Open Text)
If injuries, wounds, bruises present, describe them and how they occurred:	(Open Text)		
List all other medical concerns:	(Open Text)		

Have you ever been to a doctor or stayed in a hospital?	☐ Yes ☐ No	**If yes, please list any visit or stay for any reason. Also include visits to other healers or alternative treatment providers:**	(Open Text)
Do you have a history of tuberculosis?	☐ Yes ☐ No	**If yes, explain:**	(Open Text)
Do you have a history of seizures or convulsions?	☐ Yes ☐ No	**If yes, explain:**	(Open Text)
Do you have any scars, birthmarks, or tattoos? (Client should not disrobe to show marks)	☐ Yes ☐ No	**If yes, explain:**	(Open Text)

Mental Health (Check all that apply)

If the child answered "Yes" to any of the below mental health questions and/ or if any concerning behaviors were observed or reported, immediately report your concerns to the lead Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on the need to seek mental health care.

Concern	Yes/ No
Hurt or injured yourself?	☐ Yes ☐ No
Had urges to beat, injure, or harm someone?	☐ Yes ☐ No
Injured anyone?	☐ Yes ☐ No
Wished you could go to sleep and not wake up or thought of ending your life??	☐ Yes ☐ No
Attempted suicide?	☐ Yes ☐ No
Heard voices that others do not?	☐ Yes ☐ No
Seen things or people that others do not see?	☐ Yes ☐ No

Had trouble controlling anger or violent behavior?	☐ **Yes** ☐ **No**
Please explain any checked answers above:	(Open Text)

Observable emotional concerns (Check all that apply)

Concern	Yes / No		
Cooperative	☐ **Yes** ☐ **No**		
Uncooperative	☐ **Yes** ☐ **No**		
Alert	☐ **Yes** ☐ **No**		
Distracted	☐ **Yes** ☐ **No**		
Calm	☐ **Yes** ☐ **No**		
Excited	☐ **Yes** ☐ **No**		
Nervous	☐ **Yes** ☐ **No**		
Agitated	☐ **Yes** ☐ **No**		
Confused	☐ **Yes** ☐ **No**		
Sad	☐ **Yes** ☐ **No**		
Angry	☐ **Yes** ☐ **No**		
Other	☐ **Yes** ☐ **No**	**If yes, specify:**	(Open Text)

Safety Assessment

If the child answered "Yes" to any of the below safety assessment questions, immediately report concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on how to ensure the child's safety.

Do you feel safe now?	☐ **Yes** ☐ **No**	**If no, explain:**	(Open Text)
Do you fear that someone will harm you?	☐ **Yes** ☐ **No**	**If no, explain:**	(Open Text)
Angry?	☐ **Yes** ☐ **No**		
Other?	☐ **Yes** ☐ **No**	**If yes, specify:**	(Open Text)
Are you currently having thoughts of harming or injuring yourself or someone else?	☐ **Yes** ☐ **No**	**If yes, specify:**	(Open Text)

Explain to the child where the child's room will be located in the facility, the number of potential roommates, the age and sex of the roommates, and the bathroom and shower area associated with the potential room assignment. After having explained this, does the child identify any specific fears about this potential housing assignment?

☐ **Yes** ☐ **No**	**If yes, Explain:**	(Open Text)
Do you need anything right now?	(Open Text)	

	>| Add New Row
INTERVIEW SUMMARY OF CRITICAL ISSUES THAT NEED IMMEDIATE ATTENTION: List any issues rated above as urgent or significant and your actions to address them. Deliver this form to the Lead Case Manager, or	**ACTIONS TAKEN: Each action should correspond with the issues noted at left.**

other SUPERVISOR designated to follow-up care.			
1	(Open Text)	**1**	(Open Text)
2	(Open Text)	**2**	(Open Text)
3	(Open Text)	**3**	(Open Text)

Staff Signature:	(Open Text)	**Date/ Time:**	(Open Text) MM/DD/YYYY	(Open Text) HH:MM AM/ PM
Staff Name:	(Open Text)			
Staff Title:	(Open Text)			
Translator Signature:	(Open Text)	**Date/ Time:**	(Open Text) MM/DD/YYYY	(Open Text) HH:MM AM/ PM
Translator Name:	(Open Text)			
Language:	**<Dropdown Menu>** (-Select Language- *See Reference Table 1 – Language*)			

>| Save **>| Reset**

APPENDIX: Reference Tables

Reference Table 1: Languages

<Dropdown Menu> (- Select Language – *Spanish; Acateco; K'iche'; Q'eqchi; Mam; Non-verbal; Sign Language; Unknown Dialect; Achi; Albanian; Arabic; Armenian; Asante; Awakatek; Azerbaijani; Bambara; Bengali; Cantonese Chinese; Chatino; Chechen; Chorti; Chuj; Creole – Haitian (French); Creole – Spanish; Czech; Dari; Dutch; Eman; English; Ewe; Fanti; Farsi (Persian); French; Fujianese; Fulani; Fuzhou; Ga; Garifuna; Georgian; German; Gujarati; Haryanvi; Hausa; Hebrew; Hindi; Hungarian; Italian; Ixil; Jacatelco (Popti); Japanese; Kaqchikel; Kikongo; Korean; Kotokoli; Kurdish; Kyrgyz; Lachi; Latvian; Lenka; Lingala; Malinke; Mandarin Chinese; Mandingo; Marwari; Maya; Mazatec; Miskito; Mixteco; Mopan; Nahuatl; Nepali; Otomi; Pashai; Pashto; Patois; Polish; Poqomam; Poqomchi; Portugese; Pular; Punjabi; Qanjobal; Quechua; Rohingya; Romani (Gypsy); Romanian; Russian; Serbian; Sipakapense; Slovak; Somali; Soinke; Susu; Swahili; Sylheti; Tajik; Tamil; Tarahumara; Tectiteco; Telugu; Thai; Thibetan; Tigrinya; Tlapanec; Tojolabal; Triqui; Turkish; Twi; Tzeltal; Tzotzil; Tz'utujil; Ukranian; Urdu; Uspanteko; Uzbek; Vietnamese; Wolof; Yoruba; Zaghawa; Zapotec; Zarma; Zoque*)

Reference Table 2: Relationship

<Dropdown Menu> (-Select Relationship – *Adult First Cousin; Adult Nephew; Adult Niece; Aunt; Brother; Brother-in-law; Daughter; Daughter-in-Law; Family Friend; Father; First Cousin; Goddaughter; Godfather; Godmother; Godson; Granddaughter; Grandfather; Grandmother; Grandson; Half-sibling; Institutional/ Organizational Sponsor; Legal Guardian; Mother; Nephew; Niece; Other Cousin; Other Distant Relative; Parent's Partner; Qualified Step Parents; Sister; Sister-in-Law; Son; Son-in-law; Sponsor's Partner; Stepdaughter; Stepbrother; Stepfather; Stepmother; Stepson; Stepsister; UAC Spouse; Uncle; Unknown; Unrelated Sponsor)*