



WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

April 10, 2017

ALL COUNTY LETTER (ACL) NO. 17-29

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY REFUGEE COORDINATORS  
ALL COUNTY ADULT PROTECTIVE SERVICES PROGRAM MANAGERS  
ALL COUNTY WELFARE-TO-WORK COORDINATORS  
ALL COUNTY CALFRESH COORDINATORS  
ALL COUNTY CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CALWORKS) PROGRAM SPECIALISTS  
ALL COUNTY CIVIL RIGHTS COORDINATORS  
ALL COUNTY FISCAL OFFICERS  
ALL COUNTY CONSORTIUM PROJECT MANAGERS  
ALL COUNTY CASH ASSISTANCE PROGRAM FOR IMMIGRANTS CONTACTS  
ALL COUNTY IN-HOME SUPPORTIVE SERVICES PROGRAM MANAGERS

SUBJECT: REVISED UNITED STATES REPATRIATION PROGRAM FORMS

REFERENCE: TITLE XI, SECTION 1113, SOCIAL SECURITY ACT; CODE OF FEDERAL REGULATIONS 45, PARTS [211-212](#); MANUAL OF POLICIES AND PROCEDURES SECTION [68-100](#); ALL COUNTY INFORMATION NOTICE (ACIN) NO. [I-43-09](#) DATED JUNE 3, 2009; ACIN [I-27-10](#) DATED APRIL 8, 2010; ACIN [I-41-15](#), DATED JUNE 30, 2015; ALL COUNTY LETTER NO. [00-65](#), DATED SEPTEMBER 21, 2000; OFFICE OF REFUGEE RESETTLEMENT INFORMATION MEMORANDUM [16-02](#), DATED JUNE 20, 2016.

The purpose of this letter is to inform counties that, effective July 1, 2016, revised repatriation program forms must be used. These new forms may be found in the [U.S. Repatriation Program Welcome Package](#) and in the Office of Refugee Resettlement Information Memorandum (IM) [IM 16-02](#). Hyperlinks to the new forms and other program-related information are found below. Additionally these forms are included as attachments.

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

### **Revised Forms**

- RR-03 - [Repatriation Loan Waiver and Deferral Request Form](#) (replaces 379 Medicare Waiver Request Form).
- RR-04 - [Non-Emergency Monthly Financial Statement Form](#) (replaces SSA - 3955 Form).
- RR-05 - [Privacy and Repayment Agreement Form](#).
- RR-06 - [Refusal of Temporary Assistance Form](#).
- RR-07 - [Temporary Assistance and Extension Request Form](#).

### **Additional Repatriation Program Information**

For additional information visit the International Social Services website at [www.iss-usa.org/](http://www.iss-usa.org/), the Office of Refugee Resettlement Repatriation page at [www.acf.hhs.gov/orr/programs/repatriation](http://www.acf.hhs.gov/orr/programs/repatriation) or see the Refugee Programs Bureau Repatriation Fact Sheet found at [www.cdss.ca.gov/inforesources/Repatriation](http://www.cdss.ca.gov/inforesources/Repatriation).

Any questions regarding this notice may be directed to the Refugee Programs Bureau main phone number at (916) 654-4356.

Sincerely,

### ***Original Document Signed By:***

TODD BLAND, Deputy Director  
Welfare to Work Division

**DEPARTMENT OF HEALTH & HUMAN SERVICES  
ADMINISTRATION FOR CHILDREN AND FAMILIES**

330 C Street S.W., Washington D.C. 20201  
Telephone: 202-401-9246

**U.S. REPATRIATION PROGRAM  
Repatriation Loan Waiver and Deferral Request Form**

Submitted for Government Action on Claims due the United States

(NOTE: Use additional pages where space on this form is insufficient or continue on reverse side of pages)

**Instruction and Information:** This form is to be completed by individuals who have received temporary assistance through the United States (U.S.) Department of Health and Human Services (HHS) Repatriation Program, and want to request a waiver or deferral of their repatriation loan. In addition, this form can be completed by:

- Adults applying on behalf of themselves and dependents;
- Adult representative of a minor child (parent, guardian, or legal representative);
- Adult representative of a mentally or physically impair adult.

The U.S. Repatriation Program may perform an investigation and at its discretion to determine whether to waive the whole or any portion of a repatriation loan. In addition, it may grant a deferral instead of a waiver if it is determined that the prospects of future collection are promising enough to justify periodic review of the debt. Eligibility determinations are made by Office of Refugee Resettlement in accordance to 45 CFR 211.13 and 212.7.

This form must be submitted to the U.S. Repatriation Program at the above listed address. Application must include necessary supporting documentation. For more information or to obtain an electronic copy of this form, please visit the U.S. Repatriation Program website at: <http://www.acf.hhs.gov/programs/orr/programs/repatriation>.

DO NOT complete this form if you are looking for a payment plan. For inquiries related to your debt collection and payment plan, please contact the HHS Program Support Center at: Division of Financial Operations, Program Support Center, 1000 Ardennes Avenue, Suite 200, Rockville, MD 20857. Telephone: 301-443-4845.

Authority for the solicitation of the requested information is one or more of the following: 24 U.S.C. §§ 321-329 and 42 U.S.C. §§ 1395a, 45 CFR Parts 211 and/or 212. Use additional sheets, with your name listed on each sheet and continue on the reverse side if space on this form is insufficient. The principal purpose for gathering this information is to evaluate the substantial financial capacity of the U.S. Repatriation Loan. Disclosure of information requested on this form, including but not limited to the social security number, is voluntary. If the requested information is not furnished, the Government will pursue immediate and full payment of the repatriation loan.

Please contact ACF immediately if there are any changes to the information provided on this form.

THE PAPERWORK REDUCTION ACT OF 1995 (44 U.S.C. 3501-3509) requires that the reporting burden for this collection of information is estimated to average 0.30 hour per response, including the time for reviewing instructions, gathering existing data needed, reviewing the collection of information, and completing the review of information. An agency may not conduct or sponsor a collection of information unless it displays a valid OMB control number.

Personal information provided on this form may only be used for program purpose and under the conditions prescribed in 211.14 or 212.9.

**PART I: REPATRIATE INFORMATION**

1. I am requesting (select one):

Waiver

☐

Deferral

☐

1. Name ( <i>Repatriate</i> )	2. Birth Date (DD/MM/YYYY)
3. Home Address (Street–City–State–Zip) This address is <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary?	4. Phone/e-mail:
5. Name of Spouse/Legal Guardian ( <i>give address if different from yours</i> )	6. Date of Birth (DD/MM/YYYY)

2. **Number of individuals included in this application:** \_\_\_\_\_ Complete the below table for each waiver/deferral applicant

Last Name	First Name	DOB (DD/MM/YYYY)	Social Security Number	Relationship
				Self

**PART II: PUBLIC ASSISTANCE**

Complete the below table if you are receiving and/or are expecting to receive public assistance. Provide documentation whenever applicable (e.g. copy of SSI eligibility letter)

Applicant's name	Type of assistance applied for (E.g. TANF, SSI, Medicaid, Section 8)	Date application was submitted	Application Status: Pending, Approved, denied, other	Date application was accepted	Amount receiving or expecting to receive
Self					

**PART III: REPATRIATE EMPLOYMENT AND INCOME INFORMATION**1. Are you able to work? ☐ YES: complete below information ☐ NO: If your answer is no, please provide a written explanation or documentation whenever applicable (e.g. doctor's note, SSI eligibility letter)

Occupation		How Long in Present Employment?	
Present Employer's Name	Address		Phone No

2. **Legal guardian employment information:** complete this section if filling on behalf of a minor or mentally/physically impaired adult

Occupation		How Long in Present Employment?	
Present Employer's Name	Address		Phone No.

3. **Household Monthly Income:** complete the below table and include the total amounts per household. Provide documentation whenever applicable (e.g. paystubs).

Name	Salary or Wages \$	Income received from or for the dependent (e.g. child support, SSI) (\$)	Other income (e.g. rent) \$

4. **Assets:** List all assets and total amount per asset owed by the individual/s requesting this waiver/deferral both in the U.S. and overseas

Assets	Total amount (\$)	Year received or expected to receive
Personal property in excess of \$1,500		
All transfers and/or sells (e.g. gift, loan) made within the last 3 years from which you made a profit of \$1,500 or more		
Other: please specify		
Other: please specify		

#### PART V: FIXED MONTHLY EXPENSES AND LIABILITIES:

Complete below information if you are paying out of pocket and no assistance is received to cover these costs. For instance, you should not include your medical bills if they are covered by your medical coverage. However, the amount that you are responsible for should be included. Example, medical bill is \$2,000 and you are responsible for 10% of the bill, the amount you will list is \$200.

Expenses and Liabilities	Monthly payment	Total amount currently owed
Food		
Rent		
Mortgage: If different from rent		
Utilities		
Transportation		
Hospitals/Doctors/prescription		
Lawyer		
Car		
Furniture		

Clothes		
Taxes owed		
Insurance: Specify		
Credit cards		
Child support		
Other Loans: Specify		
Other: Specify		
<b>Total per month \$</b>		

## PART X: GENERAL QUESTIONS

- Answer each question by checking the Yes or No selection. For every question marked “**Yes**” you must provide an explanation in the below space provided.

Question	Yes	No
1. Are you a party of any pending lawsuit?		
2. Do you have any claims from which you expect to receive any income or resources? Claims against any individual, trust or state, partnership, corporation, or government?		
3. Do you have any claims against any individual, trust, partnerships, corporations, or government?		
4. Are you a trustee, executor, or administrator of any estate?		
5. Is there anybody holding money on your behalf?		
6. Will you receive or inherit any financial assets within the next two years?		
7. Do you receive or expect to receive benefits from any established trust, claim for compensation or damages, contingent on future interest in property of any kind?		
8. Do you receive or expect to receive federal, state, or local cash refund?		

- Below, provide an explanation to all YES answers to Part X, question #1. Use additional pages, as needed.

Title 18 of the United States Code 1001 states that an individual who “knowingly and willfully - (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years...or both”

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Signature: Repatriate should sign this form unless he/she is a minor or an adult with a mental or physical condition medically prevents them from signing this form.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Administration for Children and Families  
U.S. REPATRIATION PROGRAM

Non-Emergency Monthly Financial Statement Form

330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

(NOTE: Instructions are in the back of this form. Use additional pages where space on this form is insufficient or continue on reverse side)

<b>(1) Case Name:</b> List First, Last, middle initial 1. 2. 3. 4.		<b>2. Last 4 of the SSN</b> 1. 2. 3. 4.		<b>(3) Case Number</b>  <b>(4) Do you recommend a loan waiver or deferral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>(5) Reason for Repatriation</b> <input type="checkbox"/> Destitution <input type="checkbox"/> Mental Illness <input type="checkbox"/> International Crisis Emergency Repatriation <input type="checkbox"/> Medical Illness (Diagnosis, if known) <input type="checkbox"/> Other		<b>(6) Composition:</b> total number Adults:      Minors:      Females:      Males:  <b>(7) This report covers the following period: MM/DD/YYYY</b> From: ____/____/____ To: ____/____/____			
<b>(8) Repatriate's Current Address:</b>  <b>Telephone:</b> <b>E-mail:</b>		<b>(9) Is this case closed?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>(10) Check if claim initiated</b> Initiated <input type="checkbox"/> Cancel/Refund <input type="checkbox"/>	
<b>(11) Expenditures:</b> information should include actual costs, NO estimates					
Cash Assistance	\$	Food	\$		
Transportation	\$	Administrative Cost			
Hospital	\$	Other (specify)			
Other Medical Facility	\$	Other (specify)	\$		
Children Services	\$	Other (specify)			
Escort	\$	Other (specify)	\$		
Temporary Billeting/Shelter	\$	Other (specify)	\$		
<b>(12) By signing this form the signatory acknowledges that he/she has requisite authority to enter and submit this form. In addition, by signing this form the signatory certifies that the above information is correct to the best of his/her knowledge and that payment for the expenditures has not been received for previously submitted.</b>					
<b>Agency Name</b>		<b>Address-Telephone - e-mail - fax</b>			
<b>Signature/ Print of Agency Official</b>					

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13): Public reporting burden for this collection of information is estimated to average 150 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Service, Paperwork Project (0142-0002), Washington, DC 20503. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Personal information provided on this form may only be disclosed for program purposes or under the conditions prescribed in 45 CFR 211.14 or 212.9. Title 18 of the United States Code 1001 states that any individual who "knowingly and wilfully - (1) falsifies,

conceals, or covers up by any trick, scheme, or device a material fact; **(2)** makes any materially false, fictitious, or fraudulent statement or representation; or **(3)** makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years...or both"



**Administration for Children and Families (ACF)**  
**Office of Refugee Resettlement (ORR)**  
330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

**U.S. REPATRIATION PROGRAM**  
**Non-Emergency Monthly Financial Statement Form**  
**GENERAL INSTRUCTIONS**

**Purpose:** A single form will be used by the state agency and/or authorized ORR providers to report expenditures and claim reimbursement for assistance furnished to individual repatriation cases referred by ORR or its grantee in the United States (U.S.) contingent to the provisions found under the Public Law 86-571 and/or Public Law 87-64, as amended, and policies issued thereunder. This form will be used for single cases unless or until the volume and nature of the cases assisted in any State is such that group reporting is indicated.

**General:** This form should be completed by designated state agencies and authorized ORR providers to request reimbursement of reasonable and allowable costs incurred as a result of the temporary assistance provided in the U.S. citizens and their dependents after their Department of State (DOS) repatriation from overseas. By completing this form the signatory confirms that identified expenditures have been made in accordance with 45 C.F.R. 211 and 45 CFR 212, and procedures prescribed for the U.S. Repatriation Program (Program). Reimbursement is contingent upon availability of the U.S. Repatriation Program (Program) funds.

**When to submit a claim:** Claims are to be submitted monthly, by the end of the month and no later than 15 days after the close of the month. Signed form with supporting documentation should be sent to the designated ORR staff and/or grantee, with a transmittal letter (see below). If the claim cannot be submitted within the 15-day grace period, the state should notify ORR or designated grantee regarding claims expected to be submitted during the preceding month. This prompt notification of estimated costs is critical and necessary in order to ensure the claim will be considered when received.

**Instructions for preparing this form:** reimbursement is contingent upon proper and timely submission of a complete financial claim, which included necessary supporting documentation (e.g. copies of receipts, signed vouchers, and case management notes).

1. Enter the repatriates' information. One case may include a person or the members of a family.
2. Enter the last 4 digits of the Social Security Number per repatriate.
3. Case number: use the case number listed on the initial referral
4. Check whether you recommend a repatriation waiver and/or deferral of the loan amount. If you check yes, ORR and/or designee will notify the repatriate and initiate the internal waiver/deferral investigative process.
5. Check the reason for repatriation. This information is provided within the referral. You can check one or more.
6. Indicate the composition of this case by entering the total number of adults and minors included in this form. In addition, indicate how many repatriates are female vs. males.
7. Indicate the period in which the state is claiming a cost.
8. Provide the most updated repatriate's contact information, including the address, telephone, and e-mail, if available.
9. Case close: enter "Y" for yes or "N" for No. Once a repatriate has their immediate needs met, the case should be closed. Prompt notification of closure should be provided in writing (e.g. via e-mail) to ORR or its

designated agency. You should not wait until this form is completed to notify ORR or its designated agency that a case has been closed.

10. Type of claim: check the box that correlates with the type of claim submitted per case
  - i. Initial Claim: if this is the first claim submitted by the agency on this case
  - ii. Interim Claim: if the agency has submitted a previous claim on this case and expects to submit further claims.
  - iii. Final Claim: if this is the last claim the agency will submit on this case.
  - iv. Cancellation and refunds: if any item claimed as an expenditure in a previous month is later cancelled, voided, or refunded (e.g. not needed or changed in amount), it must be reported as a minus (-) expenditure and deducted from the claim. Provide a brief explanation, including reference to the period indicated on the related claim previously paid. Under certain circumstances, the agency may need to repay or reimburse ORR for the funds previously disbursed, canceled, or refunded. Instructions will be provided by authorized ORR if there is a need for reimbursement.
11. Expenditures include total amount on temporary assistance and administrative costs per category. Claimed expenditures should be on an as-paid basis (e.g. checks issued) during the reporting period. All expenses should be reasonable, allowable, and allocable. Reimbursement is contingent upon available resources.

Temporary assistance is defined by 42 U.S.C. 1313 as money payments, medical care, temporary shelter, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services), furnished to U.S. citizens and their dependents for up to 90 days. Guidance has been provided regarding temporary assistance and how and when to provide these temporary services. For more information regarding temporary assistance, please look at available repatriation program manuals and guidelines or contact ORR or its designated agency. Below, please find information regarding potential expenditures:

- a. **Transportation:** most cost efficient expense directly associated to in-state repatriate's necessary travel. For instance from port of entry (POE) to resettlement place (e.g. shelter). Supporting documentation must be attached (e.g. signed voucher for bus ticket, taxi receipt).
- b. **Hospital:** Hospital bills may be reimbursed for services provided to eligible repatriates, when not covered by other means. If other means are available but do not cover 100% of the bill, generally the Program will not pay for the uncovered expenses. For covered expenses, the Program will follow the Medicaid and/or Medicare process and rates.
- c. **Nursing Home or other authorized facility (e.g. Assisted Living Facility):** amount paid for the care of eligible repatriates. Specify daily or monthly rate, whichever is applicable. Also follow description provided under "**Hospital.**"
- d. **Other Medical:** most cost efficient expense associated to medical costs not covered under bullets letter c and d. It may include prescribed medications. Supporting documentation, such as a copy of the paid medical receipt is required.
- e. **Children services:** expenses associated to the care of minors. Not including minors who have been under the care of Child Protective Services.
- f. **Escort services:** This service must be pre-approved by authorized ORR staff.

- g. **Cash:** use TANF rates for the amount to be disbursed to a repatriate. Agencies are to evaluate the repatriates' needs for cash prior to issuing the check. In addition, costs associated to other expenses (e.g. transportation, temporary shelter, clothes) may be deducted from designated cash amount. Signed vouchers and/or copies of the paid check can serve as supporting documentation.
  - h. **Temporary Billeting/Shelter:** cost for temporary and reasonable shelter accommodation, whenever public shelters and/or other housing assistance programs are not available to the repatriates.
  - i. **Vocational training:** cost efficient expense used to assist the repatriate obtains certain job minimum required skill (e.g. GED). It does not cover long term education or college (including technical school) degrees. It is pre-approved by ORR.
  - j. **Food:** expenses associated to repatriate's temporary food supply.
  - k. **Other:** temporary assistance expense not listed above. Specify and provide supporting documentation.
  - l. **Administrative:** staff expenses directly associated to the provision of temporary services to eligible repatriates. Supporting statements (e.g. case workers' notes) and actual bills or receipts (e.g. parking receipt, taxi) must accompany the claim. Training and/or tips are not considered administrative costs.
12. Enter the name of the agency that will be receiving reimbursement from ORR. Provide reliable contact information for the person with authority to submit this claim on behalf of the agency. The signatory has the authority to certify that the state and/or service provider accepts responsibility for the correctness of the claim even though the expenditures were actually incurred by a different jurisdiction including a local jurisdiction of the state.

**Document maintenance:** case records, fiscal record supporting expenditures, including vendor bills invoices, vouchers, receipts, and cleared checks will be maintained by the agency and identified for audit purposes.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
ADMINISTRATION FOR CHILDREN AND FAMILIES  
330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

U.S. REPATRIATION PROGRAM  
PRIVACY AND REPAYMENT AGREEMENT FORM

☐ Check this box if you are completing and signing this form on behalf of the repatriate. Please know that the repatriate must sign this form unless he is a minor or an adult with a physical or mental condition that prevents him/her from signing this form. You must be an authorized representative in order to sign on behalf of the repatriate. Print the below information if you are signing on behalf of the repatriate:

Representative Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Note:** Furnishing the information on this form, including but not limited to the social security number, is voluntary. However, if you fail to provide the requested information, you may be found ineligible for repatriation assistance.

PRIVACY ACT STATEMENT

I, (print repatriate's name) \_\_\_\_\_, authorize the Department of Health and Human Services (HHS), U.S. Repatriation Program (Program), to collect and have access to my protected health information (PHI) and to disclose my PHI to other Federal, State or private organizations, if necessary to enable the HHS to carry out its responsibilities under 42 U.S.C. 1313 and 24 U.S.C. Sections 321 through 329, or to enable another Federal agency to carry out any functions related to my return from a foreign country and entry into the United States, or as otherwise expressly authorized by appropriate HHS staff.

ACCEPTANCE OF REPATRIATION SERVICES AND REPAYMENT AGREEMENT

I understand that all financial, medical, transportation and other temporary assistance provided to me through the Program will be repaid, unless a waiver is granted by authorized HHS officer. I understand that I will be billed by the HHS directly or through its designee for the cost of this aid, and I agree to repay this amount in full. Repayment of my first installment of payment is due 30 days after billing. If I pay by installment, or am delinquent in repayment, interest on the current unpaid balance by the U.S. Secretary of Treasury for private consumer loans will accrue on the unpaid portion until I repay in full. If I receive, I agree to report all changes in my address to HHS at 330 C Street S.W., Washington D.C. 20201, on (202) 401-9246. Attention: Repatriation Program.

Repatriate's Name (print) Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Repatriate Social Security Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I understand and agree to all terms and conditions of the Privacy Act Statement and the Repayment Agreement, and certify that the information provided above is true. **All payments must be sent to HHS, U.S. Repatriation Program, Attention: Repatriation Collections Office, 12000 Rockville Pike, Suite 100, Rockville, MD 20850. Tel: (202) 401-9250.**

Signature: \_\_\_\_\_

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DEPARTMENT OF HEALTH & HUMAN SERVICES  
ADMINISTRATION FOR CHILDREN AND FAMILIES  
330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

U.S. REPATRIATION PROGRAM  
REFUSAL OF TEMPORARY ASSISTANCE FORM

**Instruction for intake person or service provider:** before distributing this form please verify that the signatory level of literacy and language skills is sufficient to allow comprehension of this form contents. In addition, minors should not be asked to complete this form. Instead, the minor's representative (parent, guardian, or legal representative) may ordinarily sign on his/her behalf. Persons with mental and physical conditions that may impede their understanding and/or completion of this form should not be required to sign it. Representative (spouse, guardian, and/or legal representative) may ordinarily sign on his/her behalf.

**Introduction:** The U.S. Repatriate Program provides temporary assistance to U.S. citizens and their dependents who are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of destitution, illness, war, threat of war, invasion, or similar crisis; and because they are without resources immediately accessible to meet their needs. The full cost for the temporary services provided must ordinarily be repaid to the U.S. Government unless a waiver has been applied for and approved.

You have been provided with information regarding this U.S. Repatriation Program and have chosen to receive assistance from this Program in connection with your return from \_\_\_\_\_ Country.

TO BE COMPLETED BY THE REPATRIATE OR AUTHORIZED REPRESENTATIVE

*I understand the information that has been provided to me, verbally and in writing, and decline assistance offered by the U.S. Repatriation Program. Please supply the below information and check the box indicating whether you are the authorized representative or repatriate.*

Repatriate

☐

Authorized Representative

☐

Type Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness by \_\_\_\_\_

Case worker signature

Intake person notes:

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13): Public reporting burden for this collection of information is estimated to average 0.05 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed to complete the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Personal information provided on this form may only be disclosed for program purposes or under the conditions set forth in 45 CFR 211.14 or 212.9.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
ADMINISTRATION FOR CHILDREN AND FAMILIES  
330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

U.S. REPATRIATION PROGRAM  
Temporary Assistance and Extension Request Form

(NOTE: Use additional pages where space on this form is insufficient or continue on reverse side of pages)

**INSTRUCTIONS:** Please complete ONE FORM per individual or nuclear family. Include extra pages if space is not sufficient to provide the requested information. Please WRITE the applicant's name on the right hand corner of each additional page.

**Who is eligible?** Individuals with an open repatriation case with the Department of Health and Human Services (HHS) who are determined to be handicapped in attaining self-support or self-care for such reasons as age, disability, and lack of educational preparation as defined by 45 CFR 211.2 & 212. Applicants must submit this form with all applicable supportive evidence. Final eligibility determinations are made by authorized HHS Repatriation Program staff. Timely submission is highly recommended, at least two weeks prior to the last eligibility date. Applications submitted after the eligibility period may not be reviewed and will generally result in ineligibility. Failure to provide all supportive documents may result in denial and/or delays. No retroactive services are provided through this program.

**Who should complete this form?** Below is a list of who can sign this form:

Only those who fall within the above question 1

Adults applying for themselves

- Adults applying on behalf of themselves and dependents
- Adult representative of a minor child (parent, guardian, or legal representative)
- Adult representative of a mentally or physically impaired adult

**Disclaimer:** The statutory authority for this collection is 42 U.S.C. Section 1313 and 24 U.S.C. Sections 321 through 325 of the Health Insurance Portability and Accountability Act of 1996. Information solicited on this repatriation form is for the purpose of determining your eligibility for and extension of temporary assistance under the U.S. Repatriation Program. Furnishing the information on this form is not limited to the social security number, is voluntary. However, if you fail to provide the requested information, you may be found ineligible for repatriation assistance.

Personal information provided on this form may only be disclosed for Program purposes and under the conditions set forth in 45 CFR 211.45 C.F.R.212.9.

Title 18 of the United States Code 1001 states that an individual who "knowingly and willfully - (1) falsifies, swears, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry...is fined under this title, imprisoned not more than 5 years...or both"

The Paperwork Reduction Act of 1995 (Pub. L. 104-13): Public reporting burden of this collection of information is estimated to average 0.3 hours per response, including the time for reviewing instructions, gathering existing data needed, reviewing the collection of information. An agency may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number.

This form should be returned to the [redacted] may also send electronically at:

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Repatriate's Name: \_\_\_\_\_

1. **Repatriation Case Number** (If you do not have this information, please contact your designated repatriation worker for assistance): # \_\_\_\_\_
2. **Number of eligible individuals included in this request:** \_\_\_\_\_. **Please complete the below table.**

Name (First, Middle, Last)	Social Security Number	DOB (DD/MM/YYYY)	Individual is applying for assistance (Y/N)	Relationship to Repatriate
1- Self				
2				
3				
4				
5				

**3. Who is requesting this extension? Please check ONE**

If this request is not submitted by the repatriate, please provide documentation showing that the repatriate has authorized you to act on his/her behalf (e.g. notarized letter) and/or that you have authority to submit this request on behalf of the repatriate/s (e.g. explanation letter).

- ☐ **Adult repatriate**
- ☐ **Adult repatriate applying for self and dependents**
- ☐ **State representative**
- ☐ **Adult representative of a minor child (parent, guardian, or legal representative)**
- ☐ **Adult representative of a mentally or physically impaired adult**

**4. Reason for the Extension Request:** Check the boxes that apply to your claim of being handicapped in attaining self-support or self-care.

- ☐ Age
- ☐ Disability
- ☐ Lack of vocational preparation
- ☐ Other reasons (specify): \_\_\_\_\_

**Written explanation:** Below, please provide a written explanation for each of the above selected reasons for the extension request. Use additional paper if needed. Write your name and case number on the left hand side of each additional page. In addition, attach all applicable supporting documentation to substantiate your claim. For example, if claiming disability, supportive documents may include a letter from your medical provider indicating your disability.

**5. Financial and other Services:**

- a. Are you working? ☐ Yes ☐ No
- b. What is your household monthly combined income? \$ \_\_\_\_\_
- c. Are you a party of any pending lawsuit? ☐ Yes ☐ No
- d. Do you own any assets either in the U.S. or overseas (e.g. houses, stocks, land)? If yes, provide the estimated total amount.
- ☐ Yes: \$ \_\_\_\_\_ ☐ No

**6. Available Services:** Complete the below table if you are receiving and/or are expecting to receive public assistance.

Applicant's name	Type of assistance applied for (E.g. TANF, SSI, Medicaid, Section 8)	Date application was submitted	Application Status: Pending, Approved, denied, other	Date application was accepted	Amount receiving or expecting to receive
Self					

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_