

U.S. REPATRIATE PROGRAM

Privacy Act Statement

The U.S. Repatriate Program provides funds for financial, medical, transportation and other assistance to individuals who are certified by the Department of State as repatriates in need. This assistance must be repaid to the U.S. Government by the repatriate. Section 1113 of the Social Security Act authorizes the collection of the information solicited on these repatriation forms for the purpose of determining your eligibility for such assistance.

The Department may disclose this information to other Federal, State or private organizations, if necessary to enable the Department of Health and Human Services to carry out its responsibilities under Section 1113 of the Act, or to enable another Federal agency to carry any functions related to your return from a foreign country and entry into the United States, or as otherwise expressly authorized by the Assistant Secretary for Children and Families. Furnishing the information on these forms is voluntary; however, if you fail to provide the requested information, such failure may result in your being found ineligible for repatriation assistance.

Repayment Agreement

I understand that all financial, medical, transportation and other assistance provided to me through the Repatriation Program must be repaid. I understand that I will be billed by the United States Department of Health and Human Services for the cost of this aid, and I agree to repay this amount in full. Repayment in full or my first installment payment is due 30 days after billing. If I pay by installment, or am delinquent in repayment, interest at the current rate fixed by the Secretary of Treasury for private consumer loans will accrue on the unpaid portion. Until I repay in full the aid received, I agree to report all changes in my address to the Department of Health and Human Services, Administration for Children and Families, ORR/DSL, 370 L'Enfant Promenade SW, Washington, DC 20447, Attention: Repatriation Branch.

Name (print) Last _____ First _____ MI _____

Address _____

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 by me is correct.

Signed _____ Date _____

Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing 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:

Department of Health and Human Services
Administration for Children and Families
Reports Clearance Officer/OISM
370 L'Enfant Promenade SW
Washington, DC 20447

and to

Office of Management and Budget
Paperwork Reduction Project
OMS Control No. 0970--125
New Executive Office Building
725 17th Street NW
Washington, DC 20503



**Department of Health and Human Services
Administration for Children and Families
Office for Refugee Assistance**

**Repatriation Program
Consent Form**

I, _____, authorize the
(Print)

Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), Repatriation Program (Program), to collect and have access to my protected health information (PHI) and to disclose my PHI to appropriate Program contractor/s, partner/s for the purpose of making Program Financial Decisions (PFD). PFD includes but is not limited to waivers and loan collection decisions.

Authorizing HHS/ACF/ORR/Program to collect, have access to and disclose your PHI information is volunteer. However, without your authorization, HHS/ACF/ORR/Program may be unable to proceed with your request and/or make a PFD decision regarding your case. We collect this information under the Privacy Rule authority issued pursuant to the Health Insurance Portability and Accountability Act of 1996.



ADMINISTRATION FOR CHILDREN AND FAMILIES

370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

US Repatriation Program Decline of Service Form

The U.S. Repatriation Program provides funds for temporary assistance such as financial, medical and transportation services to individuals who are certified by the Department of State as repatriates in need. This assistance is given in the form of a loan and must be repaid to the U.S. Government. Section 1113 of the Social Security Act and 45 CFR 212 and 211, authorize the collection of the information solicited on these repatriation forms for the purpose of determining your eligibility for such assistance. Please be advised that the current interest rate for all repatriation loans is 11-percent.

The Department may disclose this information to other Federal, State or private organizations, if necessary, to enable the Department of Health and Human Services to carry out its responsibilities under Section 1113 of the Act or to enable other partner agencies to carry out any function related to your return from a foreign country and entry into the United States.

Furnishing the information on this form is voluntary; however, if you fail to provide the requested information, such failure may result in ineligibility of repatriation assistance.

You have been provided with information regarding this Program and have chosen not to receive assistance from the Repatriation Program. Please complete the below information.

By signing this form I willingly decline all services offered by U.S. Repatriation Program.

Signed _____
(Repatriate signature) Date

Signed _____
Case worker/ Coordinator signature Date

<p><u>Case Manager / State Coordinator Comments:</u></p> <hr/> <hr/> <hr/> <hr/> <hr/>
