International Social Service USA

1120 N. Charles Street
Suite 300
Baltimore, MD 21202
USA

www.iss-usa.org

Dear Program Coordinator:

ISS-USA wants to encourage you to submit requests for reimbursements on a monthly, no less than quarterly basis, along with all required documents necessary to ensure prompt reimbursement of your requests.

Please follow the link to access instructions for secure electronic file submission: Instructions-for-Secure-Electronic-file-submission-to-ISS

All reimbursement requests must include the following:

1. **Cover letter** should contain name and address, telephone number, and/or email of the contact person, who the check should be made payable to with mailing address if different from contact address, and the period of time this request covers. (See attached copy of the sample cover letter)

2. **Correctly Completed forms, RR-04 Routine Repatriation Reimbursement Request** (current address of repatriate, period of time request covers, case notes, and detailed written explanation of all costs associated with the reimbursement request) as applicable, supporting documentation, originals or copies of all receipts, signed cash disbursement acknowledgement forms, vouchers etc.

3. **Signed (Repatriation Repayment and Privacy Agreement) Form RR-05 or (Refusal of Temporary Assistance) Form RR-06 must be completed.**

The blank forms and documents can be found on our website, www.iss-usa.org **Our Services→ U.S. Repatriation→ 5. Reimbursement Procedure→ Complete Reimbursement Package**
These are available to you and can be downloaded or printed on an as-needed basis.

Please do not wait until the case is closed to submit your requests for reimbursement. The fiscal year for the Repatriation Program begins on October 1st of each year and ends on September 30th, of the following year. Example:

FY 22 October 1, 2021 – September 30, 2022

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These dates are extremely important to you as you submit requests for reimbursement because DHHS-OHSEPR and ISS-USA operate within the fiscal guidelines of our contract. At the end of each fiscal year, ISS-USA reconciles and reports expenses related to the program to DHHS-OHSEPR. All funds not used must be returned. All reimbursement requests for any particular contract period not received at least 30 days after the end of a fiscal year may be in jeopardy of not being reimbursed.

Upon receipt of the above-mentioned documents, ISS-USA will process and submit your request for reimbursement to the Department of Health and Human Services Office of Human Services Emergency Preparedness and Response for review and approval.

ISS-USA encourages you to submit request for reimbursement on a monthly basis, but will accept quarterly request as well.

If you have any questions, please don't hesitate to contact me at (443) 451-1204 or Abigail Ayele, Administrative Manager at (443) 451-1217.

Sincerely,

Stephney Allen, MBA
Director of the U.S. Repatriation Program and Internal Operations

International Social Service-USA Branch
1120 N. Charles Street, Suite 300 Baltimore, MD 21201
Phone: 443-451-1200 Fax: 443-451-1200
www.iss-usa.org **iss-usa@iss-usa.org**

U. S. Repatriation Program

INSTRUCTIONS FOR SUBMITTING REQUEST FOR REIMBURSEMENT FOR REPATRIATION EXPENSES

ISS-USA handles these requests based on a cooperative agreement with the Department of Health and Human Services Office of Human Services Emergency Preparedness and Response (OHSEPR).

Please adhere to the following guidelines for requesting reimbursement.

1. A cover letter on your organizations letter head with the name, telephone number, email address of the person ISS should contact with questions or concerns, and a summary of the expenses requested.
2. All Agencies requesting reimbursements must submit:
    a. Form **RR-04 (Routine Repatriation Reimbursement Request Form)** must be completed in its entirety for each repatriate
        i. Case Name
        ii. **Last 4 of SSN**
        iii. Case Number
        iv. Waiver or deferral recommendation
        v. Reason for repatriation
        vi. Composition
        vii. Report time period
        viii. Repatriate's current address
        ix. Is case open or closed
        x. Type of claim
        xi. Expenditures
    b. Support for expenditures on form RR-04 (Non-Emergency Monthly Financial Statement)
        i. Copies of checks,
        ii. Original receipts,
        iii. Disbursement forms, etc.
        iv. Case notes for each repatriate (If multiple repatriates received services) during the time period expenses were incurred.

    c. **Form RR-04** (Expenses for the period). Remember to check if you recommend a waiver or not and please state a reason.
    d. Repatriation Repayment and Privacy Agreement Form RR-05 signed by the repatriate
    e. State Officials signatures and/or Authorized signers

<u>Useful information</u>:

Most destitute people will be: Section 1113
Mentally ill repatriates will be: Public law 86-571

<u>Common reasons for case closure:</u>

- Client is self-sufficient, no longer in need of services
- Repatriate has access to other sources of income or benefits
- The child is in foster care placement.
- Repatriate was admitted to a VA Hospital.
- The Repatriate dies upon arrival to the U.S.

Cover Letter #1

Your organizations' letter head

Date

Stephney Allen, MBA
Director of the Repatriation Program and Internal Operations
1120 N. Charles Street, Suite 300
Baltimore, MD 21201

Dear Ms. Allen:

Please find enclosed documents: the signed **U.S.** Repatriation Program RR-05 Repatriation Repayment and Privacy Agreement form and the RR-04 Routine Repatriation Reimbursement Request form with case notes supporting administrative hours, copies of all receipts, signed cash disbursement acknowledgement forms and vouchers copies regarding the repatriation case #_____. The attached reimbursement request covers the dates: from _____ to _____ with (summary of the expenses) total amount of $_____.

Please make the check payable to: name of the person or organization.

If you have any questions or concerns in regards to this request, please don't hesitate to contact: the name, telephone number, email address, address.

Thank you for your prompt attention to this request,

Sincerely,

Signature
Company/ Agency name:
Contact Person:
Address:
City, State, Zip

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Human Services
Emergency Preparedness and Response

OMB Control No: 0970-0474
Expiration Date: June 30, 2025
Estimated Burden: 20 minutes

U.S. REPATRIATION PROGRAM
ROUTINE REPATRIATION REIMBURSEMENT REQUEST

SECTION I: AGENCY INFORMATION	
1. Agency Name and Address	2. Type of Agency ☐ State ☐ Local Service Provider

SECTION II: REPATRIATE INFORMATION			
3. Case Number	4. Case Status ☐ Open ☐ Closed	5. Claim Request Period MM/DD/YYYY From: ___ /___ /___ To: ___ /___ /___	6. Type of Claim ☐ Initial ☐ Interim ☐ Final ☐ Cancel / Refund

7. Repatriate Name	8. Repatriate SSN	9. Dependent(s) Name 1. 2. 3. 4. 5.	10. Case Composition Total Number: Adults: Minors:

11. Repatriate's Current Address	12. Repatriate's Contact Information Telephone Email

SECTION III: COSTS

13. Costs for the Repatriate(s)

Costs	Total	Costs	Total
Money Payments		Administrative Costs	
Medical Care		Other (specify):	
Temporary Lodging		Other (specify):	
Transportation		Other (specify):	
Escort Services		Total	

14. Additional Comments

SECTION IV: SIGNATURE

By signing this document, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, title 18, section 1001). I also certify that the identified costs have been made in accordance with 42 U.S.C. 1313, 45 CFR 211, 45 CFR 212, 45 CFR Part 75 and procedures prescribed for the U.S. Repatriation Program.

15. Name and Title of Agency Official (Print) Name Title	16. Contact Information Telephone Email	
17. Signature		18. Date (MM/DD/YYYY)

GENERAL INFORMATION

Purpose: The purpose of this form is for state and local service providers to submit reimbursement requests for providing temporary assistance to repatriates under the U.S. Repatriation Program.

Who Should Complete this Form: This form should be completed by designated state agencies and local service providers.

When to Submit: Claims can be submitted on ongoing basis and should be submitted monthly. All requests for reimbursement must be submitted no later than 30 days following case closure. Requests submitted after one year following the date of case closure will not be reimbursed.

Where to Submit: Signed form with supporting documentation should be sent to ISS-USA, 1120 N. Charles St., Suite 300, Baltimore, MD 21201.

Disclaimer: 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."

1. State agencies or local service providers may submit a single form to report costs and claim reimbursement for temporary assistance provided to a repatriation case (individual or families) in the United States.

2. OHSEPR will reimburse only reasonable, allowable, and allocable costs incurred as a result of temporary assistance provided to U.S. citizens and their dependents in the United States after being returned by Department of State from a foreign country.

3. Reimbursement is contingent upon proper and timely submission of a complete financial claim, which includes necessary supporting documentation.

4. Reimbursement is contingent upon the availability of the U.S. Repatriation Program funds and the allowability of each cost under 42 U.S.C. § 1313, the implementing regulations at 45 CFR Parts 211 and 212, and the general grants administration regulations at 45 CFR Part 75 particularly subpart E – Cost Principles.

SPECIFIC INSTRUCTIONS

SECTION I: AGENCY INFORMATION

Item 1. Name of Agency / Address. Provide the name of the requesting state agency and the full address including street, suite number (if applicable), city, state, and zip code.

Item 2. Type of Agency. Check all that apply.

SECTION II: REPATRIATE INFORMATION

Item 3. Case number. Provide the case number associated with this case.

Item 4. Case Status. Select one of the two boxes to indicate if the case is 'closed' or 'open.'

Item 5. Claim Request Period (MM/DD/YYYY). Provide the date the case was opened and the closing date. If the case is still open, write 'present.'

Item 6. Type of Claim. Select one of the four boxes to indicate if the request is initial, interim, final, or a cancellation/ refund.

Item 7. Repatriate Name. Provide the repatriate's full name.

Item 8. Social Security Number. Provide the repatriate's nine-digit social security number.

Item 9. Dependent(s) Name. List the dependent(s) names. If there are more than five, use a separate sheet of paper.

Item 10. Case Composition. Provide the total number of individuals in this case, including the applicant. Indicate the number of minors and adults in the space provided.

Item 11. Repatriate's Current Address. Provide the repatriate's current address.

Item 12. Repatriate's Contact Information. Provide the best email and phone number, including area code, for the repatriate.

SECTION III: COSTS

Item 13. Costs for the Repatriate(s). Indicate the dollar amount provided to the repatriate for each type of cost for which the state is seeking reimbursement. Also,

provide the combined total amount of costs. Supporting documentation is required for all costs. If OHSEPR pre-approval was required and received, provide the appropriate documentation. Include any additional comments, as necessary, in the space provided.

Money Payments: Signed vouchers and copies of the paid check can serve as supporting documentation.

Medical Care: Provide bills and paid receipts for covered costs.

Temporary Lodging: Provide invoice and receipt.

Transportation: Provide signed vouchers and receipts (e.g., signed voucher for bus ticket, taxi receipt).

Escort Services: Provide invoice, receipts, and pre-approvals from OHSEPR.

Administrative Costs: Include supporting statements, such as case workers' notes, bills, and receipts (e.g., parking receipt, taxi).

Other: Identify type of temporary assistance. Provide supporting documentation detailing the assistance, the receipt for the amount paid, and OHSEPR pre-approvals if applicable.

Item 14. Additional Comments. Use this space to provide further information, if necessary.

SECTION IV: SIGNATURE

Item 15. Name and Title of Agency Official. Print the agency official's full name and title.

Item 16. Contact Information. Provide the signatory's email address and phone number.

Item 17. Signature. Sign in the space provided to confirm that the information provided on the document is true, complete, and accurate, and that the identified costs have been made in accordance with 45 CFR 211 and 45 CFR 212, and policies of the U.S. Repatriation Program.

Item 18. Date (MM/DD/YYYY). Provide the date of signature in the form of a two-digit month and day and a four-digit year.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Human Services
Emergency Preparedness and Response

OMB Control No: 0970-0474
Expiration Date: June 30, 2025
Estimated Burden: 10 minutes

U.S. REPATRIATON PROGRAM
REPATRIATION REPAYMENT AND PRIVACY AGREEMENT

SECTION I: REPATRIATE INFORMATION

1. Repatriate Last Name	2. Repatriate First Name	3. Repatriate Middle Name

4. Address (Street, City, State, Zip Code)

5. Social Security Number	6. Date of Birth (MM/DD/YYYY)	7. Phone Number	8. Email Address

SECTION II: ACCEPTANCE OF REPATRIATION SERVICES AND REPAYMENT AGREEMENT

9. Repatriation Services and Repayment Agreement

I agree to receive temporary assistance under the U.S. Repatriation Program. I understand that I must repay the U.S. Department of Health and Human Services (HHS) for all financial, medical, shelter, transportation, and other temporary assistance I received through the U.S. Repatriation Program, unless the Office of Human Services Emergency Preparedness and Response (OHSEPR) grants me a waiver. I understand that HHS will bill me directly, and I agree to repay HHS this amount in full. Payment in full is due 30 days after billing. If I pay by installment or am delinquent in repayment, interest at the current rate fixed by the U.S. Department of the Treasury for private consumer loans will accrue on the unpaid portion, in addition to any fees and penalties. Until I repay the full amount, I agree to report all changes in my address to HHS at 330 C Street S.W., Washington D.C. 20201, Attention: U.S. Repatriation Program. All payments must be sent to HHS - Program Support Center, Accounting Services – Debt Collection Center, 7700 Wisconsin Avenue, Suite 8310-A, Bethesda, Maryland 20857; Email: PSCDebtServicing@psc.hhs.gov; Telephone: 301-492-4664.

10. Privacy Act Statement

I authorize the HHS U.S. Repatriation Program (Program) to collect and have access to my personal identifiable information (PII) including my information on this form and the following Program forms: Emergency Repatriation Eligibility Application (RR-01), Loan Waiver and Deferral Application (RR-03), Routine Repatriation Reimbursement Request (RR-04), and Temporary Assistance Extension Request (RR-07), as applicable. I authorize the Program to disclose my PII to other Federal and state agencies, grantees, service providers, contractors, or private organizations, if necessary for HHS to carry out its responsibilities under 42 U.S.C. 1313 and 24 U.S.C. Sections 321 - 329, or to enable another Federal agency to carry out any functions related to my return from a foreign country to the United States, or as otherwise expressly authorized by appropriate HHS staff, in accordance with 45 CFR 211.14 and 45 CFR 212.9. Providing this information is voluntary, however failure to do so will mean HHS is unable to provide assistance.

SECTION III: SIGNATURE OF REPATRIATE / AUTHORIZED REPRESENTATIVE

By signing this document, I certify that I understand and agree to all terms and conditions of the Repayment Agreement and understand the Privacy Act Statement and certify that the information I have provided on this form is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictious, or fraudulent information may subject me to criminal, civil or administrative penalties. (U.S. Code, Title 18, section 1001)

11. Signature	12. Date (MM/DD/YYYY)

SECTION IV: AUTHORIZED REPRESENTATIVE INFORMATION (IF APPLICABLE)		
13. Representative Last Name	14. Representative First Name	15. Representative Middle Name
16. Relationship to Repatriate	17. Phone Number	18. Email Address

SECTION V: REPATRIATE DEMOGRAPHIC INFORMATION (VOLUNTARY).

Mark the applicable boxes with "X" that apply for each question. All responses are voluntary.

19. Race	20. Ethnicity	21. Marital Status
☐ American Indian / Alaskan Native (please specify) _____ ☐ Black / African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other (please specify) _____	☐ Hispanic or Latino - a person of Cuban, Mexican, Puerto Rican, Dominican, South or Central American or other Spanish culture or origin, regardless of race ☐ Non-Hispanic or Latino	☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

22. Gender	23. Primary Language	24. Are you a veteran?	25. Do you have a disability?
☐ Male ☐ Female ☐ X ☐ Other (please specify) _____ ☐ Prefer not to answer	☐ English ☐ Spanish ☐ Mandarin ☐ French ☐ Arabic ☐ Other (please specify) _____	☐ Yes ☐ No	☐ Mental ☐ Physical ☐ Emotional ☐ No If yes, please specify: _____

26. Highest Level of Education	27. Annual Household Income	28. How did you hear about the U.S. Repatriation Program?
☐ Primary school (K-8th grade) ☐ Some high school ☐ High school graduate / GED ☐ Some college ☐ College degree ☐ Advanced college degree (e.g., Master's) ☐ Doctorate or Professional Degree (e.g., PhD, JD, MD)	☐ $0 - $10,000 ☐ $10,001 - $25,000 ☐ $25,001 - $50,000 ☐ $50,001 - $75,000 ☐ $75,001 and above	☐ Flyer at Airport ☐ Friend or Family ☐ Overseas Evacuation Site ☐ Government Employee ☐ Other: _____

GENERAL INFORMATION

Purpose: This form is for the repatriate to accept temporary assistance under the U.S. Repatriation Program, agree to repay HHS for temporary assistance, and allow HHS to share personal information for benefits purposes.

Who Should Complete this Form: This form can be completed and signed by:

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

When to Submit: As soon as an eligible individual decides to apply for temporary assistance, but no later than 90 days from the repatriate's date of arrival in the United States from a foreign country.

Where to Submit: Return the signed copy to your case worker.

Disclaimer: Title 18 of the United States Code 1001 provides 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."

SPECIFIC INSTRUCTIONS

SECTION I: REPATRIATE INFORMATION

Item 1. Repatriate Last Name. Enter the repatriate's last name.

Item 2. Repatriate First Name. Enter the repatriate's first name.

Item 3. Repatriate Middle Name. Enter the repatriate's middle name. If no middle name, write "NMM."

Item 4. Address (Street, City, State, Zip Code). Enter the repatriate's U.S. address. Include apartment/unit number if applicable.

Item 5. Social Security Number. Enter the repatriate's social security number.

Item 6. Date of Birth (MM/DD/YYYY). Enter repatriate's date of birth. Format as two-digit month and day and four-digit year.

Item 7. Phone Number. Enter the primary phone number to communicate regarding participation in the U.S. Repatriation Program.

Item 8. Email Address. Enter the primary email address to send communications regarding participation in the U.S. Repatriation Program.

SECTION II: ACCEPTANCE OF REPATRIATION SERVICES AND REPAYMENT AGREEMENT

Items 9 and 10. Repatriation Services and Repayment Agreement and Privacy Act Statement. Read in full.

SECTION III: SIGNATURE OF REPATRIATE/ AUTHORIZED REPRESENTATIVE.

Item 11. Signature. Sign to indicate understanding and agreement to all terms and conditions of the Repayment Agreement and the Privacy Act Statement and to certify that the information provided on this form is correct.

Item 12. Date (MM/DD/YYYY). Provide date of signature. Format as two-digit month and day and four-digit year.

SECTION IV: AUTHORIZED REPRESENTATIVE INFORMATION (IF APPLICABLE).

Item 13. Representative Last Name. Enter the authorized representative's last name.

Item 14. Representative First Name. Enter the authorized representative's first name.

Item 15. Representative Middle Name. Enter the authorized representative's middle name. If no middle name, write "NMM."

Item 16. Relationship. Indicate the relationship of the authorized representative to the U.S. citizen (example: parent, legal guardian).

Item 17. Phone Number. Enter the primary phone number to communicate regarding participation in the U.S. Repatriation Program.

Item 18. Email Address. Enter the primary email address to send communications regarding participation in the U.S. Repatriation Program.

Items 19-28. Demographic Information. These questions are voluntary. Select appropriate box(es).

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Human Services
Emergency Preparedness and Response

OMB Control No: 0970-0474
Expiration Date: June 30, 2025
Estimated Burden: 3 minutes

U.S. REPATRIATION PROGRAM
REFUSAL OF TEMPORARY ASSISTANCE

SECTION I: INTRODUCTION

The U.S. Repatriation Program provides temporary assistance to U.S. citizens and their dependents returned by the Department of State from a foreign country to the United States because of destitution, illness, war, threat of war, invasion, or similar crisis; and who are without resources immediately accessible to meet their needs. The full cost for the temporary assistance provided must be repaid to the U.S. Government unless a waiver has been applied for and approved by the U.S. Department of Health and Human Services / Administration for Children and Families / Office of Human Services Emergency Preparedness and Response.

SECTION II: REFUSAL OF U.S. REPATRIATION PROGRAM TEMPORARY ASSISTANCE

I understand the information I have received, verbally and in writing, about temporary assistance available under the U.S. Repatriation Program, and I decline assistance.

SECTION III: SIGNATURE

1. I am:
☐ an individual eligible for the U.S. Repatriation Program and am declining assistance
☐ an Authorized Representative (relationship to individual _____)

2. Name (Last, First, Middle)	3. Date of Birth (MM/DD/YYYY)	4. Country Returned From
5. Signature	6. Date (MM/DD/YYYY)	
7. Witness (Print)	8. Date (MM/DD/YYYY)	
9. Notes:		

PAPERWORK REDUCTION ACT OF 1995 (b. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to refuse temporary assistance under the U.S. Repatriation Program. Public reporting burden for this collection of information is estimated to average 0.05 hours per respondent, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This collection of information is voluntary (42 U.S.C. Section 1313). 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 # is 0970-0474 and the expiration date is 06/30/2025. If you have any comments on this collection of information, please contact the U.S. Repatriation Program, 330 C St. SW, Washington, D.C. 20201.

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.

GENERAL INFORMATION

Purpose: For individuals eligible for the U.S. Repatriation Program to opt out of receiving temporary assistance through U.S. Repatriation Program.

For case worker or service provider: Before obtaining the individual's signature on this form, please verify that the signatory is an adult with sufficient level of literacy and language skills to understand this form. Persons with mental and physical conditions that may impede their understanding and/or completion of this form should not be required to sign it.

Who Should Sign this Form: This form can be completed and signed by the following:

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

Where to Submit: Return the signed copy to your repatriation case worker.

SPECIFIC INSTRUCTIONS

SECTION III: SIGNATURE

Item 1. Check the box according to who is filling out the form. If the individual refuses to fill out the form after refusing assistance, a case worker should note this in Item 9.

Item 2. Name (Last, First, Middle). Print name formatted as last name, first name, and middle name.

Item 3. Date of Birth (MM/DD/YYYY). Enter date of birth for the eligible individual as two-digit day and month and four-digit year.

Item 4. Country Returned From. Provide the name of the primary country the individual is returning from. This does not include airport layover countries.

Item 5. Signature. Individual's signature to indicate they have been provided with information regarding the U.S. Repatriation Program and have chosen NOT to receive assistance from this Program.

Item 6. Date (MM/DD/YYYY). Enter the date as two-digit day and month and four-digit year.

Item 7. Witness (Print). Format the witness's name as Last Name, First Name, Middle Initial.

Item 8. Date (MM/DD/YYYY). Enter the date as two-digit day and month and four-digit year.

Item 9. Notes. Include notes, if necessary.