

**ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES
 Expenditure Statement and Claim for Reimbursement**

(1) NAME OF AGENCY	STATE	FOR THE PERIOD	
		From:	To:
		, 20	, 20

THE FOLLOWING EXPENDITURES HAVE BEEN MADE BY THIS AGENCY FOR ASSISTANCE TO A UNITED STATES CITIZEN RETURNED FROM A FOREIGN COUNTRY. ASSISTANCE AND SERVICES HAVE BEEN PROVIDED IN ACCORDANCE WITH THE POLICY AND PROCEDURES PRESCRIBED FOR THIS PROGRAM.

(2) CASE NAME (FIRST NAMES OF MAN AND WIFE, IF A COUPLE):	NO. OF PERSONS:

REPATRIATED FROM (COUNTRY):	CURRENT ADDRESS

(3) A. CLASSIFICATION/AUTHORITY PUBLIC LAW 86-571 (MENTALLY ILL) <input type="checkbox"/>	C. EXPENDITURES
SECTION 1113, SOCIAL SECURITY ACT (OTHER THAN MENTALLY ILL) <input type="checkbox"/>	MEDICAL CARE \$
B. NATURE OF THIS ACTION: INITIAL CLAIM <input type="checkbox"/>	HOSPITALIZATION \$
INTERIM CLAIM <input type="checkbox"/>	NURSING HOME \$
ESTIMATED FUTHER CLAIMS \$ _____	MAINTENANCE \$
1. DATE CASE CLOSED	TRANSPORTATION \$
2. REASON CASE CLOSED	FOSTER CARE \$
3. REPAYMENT RECOMMENDED <input type="checkbox"/>	OTHER (SPECIFY) \$
4. WAIVER RECOMMENDED <input type="checkbox"/>	TOTAL \$

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(4) DESIGNATION OF STATE OFFICIAL AUTHORIZED TO RECEIVE FEDERAL FUNDS AS REIMBURSEMENT OF THIS CLAIM	
TITLE	ADDRESS

(5) THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT PAYMENT FOR THESE EXPENDITURES HAS NOT BEEN RECEIVED.

SIGNATURE OF OFFICIAL OF AGENCY	TITLE	DATE