DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration
Office of Family Assistance

ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES - REPORT ON REFERRAL

CASE NAME	COMPOSITION		BIRTH DATE OF FAMILY HEAD	SS NO.
	NO. ADULTS	NO. CHILDREN		

LAST U.S. RESIDENCE	DATE LEFT US

CURRENT ADDRESS

REPATRIATED BY DEPARTMENT OF STATE FROM:	BECAUSE OF:
	☐ MENTAL ILLNESS ☐ DESTITUTION ☐ INTERNATIONAL CRISIS ☐ OTHER ILLNESS (DIAGNOSIS, IF KNOWN)

DISPOSITION

ARRIVED U.S. (DATE)	DHHS REFERRAL RECEIVED (DATE)	INITITAL AGENCY CONTACT (DATE)

(1) FINANCIAL ASSISTANCE AUTHORIZED	DATE OF INITIAL ASSISTANCE	☐ ONE MONTH OR LESS ☐ MORE THAN ONE MONTH

TYPE OF ASSISTANCE	(A) AMOUNT - FIRST MONTH	(B) ESTIMATE - NEXT MONTH
MAINTENANCE	$	$
TRANSPORTATION		
HOSPITAL		
NURSING HOME		
OTHER MEDICAL		
FOSTER CARE		
OTHER (SPECIFY)		
TOTAL		

RESOURCES AVAILABLE TOWARD CURRENT NEEDS ☐ YES ☐ NO

(2) FUTURE PLAN	CHECK: WILL NEED ASSISTANCE UNTIL THE FOLLOWING RESOURCES WILL BE AVAILABLE →	NUMBE OF MONTHS ASSISTANCE NEEDED
	☐ OWN OR RELATIVE ☐ EMPLOYMENT ☐ INSURANCE ☐ SSI ☐ ANOTHER PUBLIC PROGRAM ☐ OTHER	

(3) RECOMMENDATION AS TO REPAYMENT OF ASSISTANCE GRANTED

(a) WILL BE ABLE TO REPAY ☐ ONE PAYMENT ☐ INSTALLMENTS DATE

(b) WAIVER RECOMMENDED (REASON)

(c) ABILITY TO REPAY NOT DETERMINED (REASON)

COMPLETED BY	TITLE

STATE	DATE

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