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# 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/DSLR, 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 ________________________

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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
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