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DEPARTMENT OF HEALTH & HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
330 C Street S.W., Washington D.C. 20201, Telephone: 202-401-9200

U.S. REPATRIATION PROGRAM
REFUSAL OF TEMPORARY ASSISTANCE FORM

Instruction for intake person or service provider: before distributing this form please verify that the signatory level of literacy and language skills is sufficient to allow comprehension of this form contents. In addition, minors should not be asked to complete this form. Instead, the minor's representative (parent, guardian, or legal representative) may ordinarily sign on his/her behalf. Persons with mental and physical conditions that may impede their understanding and/or completion of this form should not be required to sign it. Representative (spouse, guardian, and/or legal representative) may ordinarily sign on his/her behalf.

Introduction: The U.S. Repatriate Program provides temporary assistance to U.S. citizens and their dependents who are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of destitution, illness, war, threat of war, invasion, or similar crisis; and because they are without resources immediately accessible to meet their needs. The full cost for the temporary services provided, must ordinarily be repaid to the U.S. Government unless a waiver has been applied for and approved.

You have been provided with information regarding this U.S. Repatriation Program and have chosen NOT to receive assistance from this Program in connection with your return from _____.
Country

TO BE COMPLETED BY THE REPATRIATE OR AUTHORIZED REPRESENTATIVE

I understand the information that has been provided to me, verbally and in writing, and decline assistance offered by the U.S. Repatriation Program. Please supply the below information and check off the box indicating whether you are the authorized representative or repatriate.

Repatriate ☐ Authorized Representative ☐

Type Name: _____ _____
DOB

Signature: _____ _____
Date

Witness by _____ _____
Case worker or intake staff signature Date

Intake person notes:

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13): Public reporting burden for this collection of information is estimated to average 0.05 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Personal information provided on this form may only be disclosed for program purposes or under the conditions prescribe in 45 CFR 211.14 or 212.9.