International Social Service USA

1120 N. Charles Street
Suite 300
Baltimore, MD 21201
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, explain the procedure and required documents necessary to ensure prompt reimbursement of your requests.

Cover letter and mail to:

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

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 Non-Emergency Monthly Financial Statement Form** (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 (U.S. Repatriation Program Privacy and Repayment 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 **Services→ Repatriation Resources→ Repatriation Welcome Package and Forms.**
These are available to you and you can download or print them 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 19 October 1, 2018 – September 30, 2019
FY 20 October 1, 2019 – September 30, 2020

These dates are extremely important to you as you submit requests for reimbursement because DHHS 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. 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 Refugee Resettlement 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 Esther Keinkede, Finance Coordinator at (443) 451-1221.

Sincerely,

Stephney Allen
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: 443-451-1230
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 Refugee Resettlement

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 (Non-Emergency Monthly Financial Statement 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. Privacy and Repayment 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.

Your organizations' letterhead

Date

Stephney Allen
Director of U.S. 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 Privacy and Repayment Agreement form and the RR-04 Non-Emergency Monthly Financial Statement 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

OMB Control No: 0970-0474
Expiration date: 04/30/2022

DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Children and Families (ACF)

U.S. REPATRIATION PROGRAM

Non-Emergency Monthly Financial Statement Form

330 C Street S.W., Washington D.C. 20201

(NOTE: Instructions are in the back of this form. Use additional pages where space on this form is insufficient or continue on reverse side)

(1) Case Name: List First, Last, middle initial	**2. Last 4 of the SSN**	**(3) Case Number**
1.	**1.**	
2.	**2.**	**(4) Do you recommend a loan waiver or deferral?**
3.	**3.**	☐ **Yes** ☐ **No**
4.	**4.**	

(5) Reason for Repatriation
- □ Destitution
- □ Mental Illness
- □ International Crisis/Emergency Repatriation
- □ Medical Illness (Diagnosis, if known)
- □ Other

(6) Composition: total number

Adults:	Minors:	Female:	Males:

(7) This report covers the following period: MM/DD/YYYY

From: _____/_____/_____ To: _____/_____/_____

(8) Repatriate's Current Address:	**(9) Is this case closed?**	**(10) Check the type of claim**
	Yes ☐	Initial ☐
		Interim ☐
Telephone:_____**E-mail:**_____	No ☐	Final ☐
		Cancel/Refund ☐

(11) Expenditures: information should include actual costs, NO estimates

Cash Assistance	$	Food	$
Transportation	$	Administrative Cost	$
Hospital	$	Other (specify)	$
Other Medical Facility	$	Other (specify)	$
Children Services	$	Other(specify)	$
Escort	$	Other (specify)	$
Temporary Billeting/Shelter	$	**Grand Total**	$

(12) By signing this form the signatory acknowledges that he/she has requisite authority to certify and submit this form. In addition, by signing this form the signatory certifies that the above information is correct to the best of his/her knowledge and that payment for these expenditures has not been received nor previously submitted.

Agency Name	**Address-Telephone - e-mail - fax**
Signature/ Print of Agency Official	**Date**

OMB Control No: 0970-0474
Expiration date: 04/30/2022

Administration for Children and Families (ACF)
330 C Street S.W., Washington D.C. 20201

U.S. REPATRIATION PROGRAM
Non-Emergency Monthly Financial Statement Form
GENERAL INSTRUCTIONS

Purpose: A single form will be used by the state agency and/or authorized ACF providers to report expenditures and claim reimbursement for assistance furnished to individual repatriation cases referred by ACF or its grantee in the United States (U.S.) contingent to the provisions found under the Public Law 86-571 and/or Public Law 87-64, as amended, and policies issued thereunder. This form will be used for single cases unless or until the volume and nature of the cases assisted in any State is such that group reporting is indicated.

General: This form should be completed by designated state agencies and authorized ACF providers to request reimbursement of reasonable and allowable costs incurred as a result of the temporary assistance provided in the U.S. citizens and their dependents after their Department of State (DOS) repatriation from overseas. By completing this form the signatory confirms that identified expenditures have been made in accordance with 45 C.F.R. 211 and 45 CFR 212, and procedures prescribed for the U.S. Repatriation Program (Program). Reimbursement is contingent upon availability of the U.S. Repatriation Program (Program) funds.

When to submit a claim: Claims are to be submitted monthly, by the end of the month and no later than 15 days after the close of the month. Signed form with supporting documentation should be sent to the designated ACF staff and/or grantee, with a transmittal letter (see below). If the claim cannot be submitted within the 15-day grace period, the state should notify ACF or designated grantee regarding claims expected to be submitted during the preceding month. This prompt notification of estimated costs is critical and necessary in order to ensure the claim will be considered when received.

Instructions for preparing this form: reimbursement is contingent upon proper and timely submission of a complete financial claim, which included necessary supporting documentation (e.g. copies of receipts, signed vouches, and case management notes).

1. Enter the repatriates' information. One case may include a person or the members of a family.
2. Enter the last 4 digits of the Social Security Number per repatriate.
3. Case number: use the case number listed on the initial referral
4. Check whether you recommend a repatriation waiver and/or deferral of the loan amount. If you check yes, ACF and/or designee will notify the repatriate and initiate the internal waiver/deferral investigative process.
5. Check the reason for repatriation. This information is provided within the referral. You can check one or more.
6. Indicate the composition of this case by entering the total number of adults and minors included in this form. In addition, indicate how many repatriates are female vs. males.
7. Indicate the period in which the state is claiming a cost.
8. Provide the most updated repatriate's contact information, including the address, telephone, and e-mail, if available.
9. Case close: enter "Y" for yes or "N" for No. Once a repatriate has their immediate needs met, the case should be closed. Prompt notification of closure should be provided in writing (e.g. via e-mail) to ACF or its designated agency. You should not wait until this form is completed to notify ACF or its designated agency that a case has been closed.

10. Type of claim: check the box that correlates with the type of claim submitted per case
    i. Initial Claim: if this is the first claim submitted by the agency on this case
    ii. Interim Claim: if the agency has submitted a previous claim on this case and expects to submit further claims.
    iii. Final Claim: if this is the last claim the agency will submit on this case.
    iv. Cancelation and refunds: if any item claimed as an expenditure in a previous month is later cancelled, voided, or refunded (e.g. not needed or changed in amount), it must be reported as a minus (-) expenditure and deducted from the claim. Provide a brief explanation, including reference to the period indicated on the related claim previously paid. Under certain circumstances, the agency may need to repay or reimburse ACF for the funds previously disbursed, canceled, or refunded. Instructions will be provided by authorized ACF if there is a need for reimbursement.

11. Expenditures include total amount on temporary assistance and administrative costs per category. Claimed expenditures should be on an as-paid basis (e.g. checks issued) during the reporting period. All expenses should be reasonable, allowable, and allocable. Reimbursement is contingent upon available resources.

    Temporary assistance is defined by 42 U.S.C. 1313 as money payments, medical care, temporary shelter, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services), furnished to U.S. citizens and their dependents for up to 90 days. Guidance has been provided regarding temporary assistance and how and when to provide these temporary services. For more information regarding temporary assistance, please look at available repatriation program manuals and guidelines or contact ACF or its designated agency. Please see the following information regarding potential expenditures:

    a. **Transportation:** most cost efficient expense directly associated with in-state repatriate' necessary travel. For instance from port of entry (POE) to resettlement place (e.g. shelter). Supporting documentation must be attached (e.g. signed voucher for bus ticket, taxi receipt).

    b. **Hospital:** Hospital bills may be reimbursed for services provided to eligible repatriates, when not covered by other means. If other means are available but do not cover 100% of the bill, generally the Program will not pay for the uncovered expenses. For covered expenses, the Program will follow the Medicaid and/or Medicare process and rates.

    c. Nursing Home or other authorized facility (e.g. Assisted Living Facility): amount paid for the care of eligible repatriates. Specify daily or monthly rate, whichever is applicable. Also follow description provided under **"Hospital."**

    d. Other Medical: most cost efficient expense for medical costs not covered under bullets letter c and d. It may include prescribed medications. Supporting documentation, such as a copy of the paid medical receipt is required.

    e. Children services: expenses associated with the care of minors. Not including minors who have been under the care of Child Protective Services.

    f. Escort services: This service must be pre-approved by authorized ACF staff.

g. **Cash:** use TANF rates for the amount to be disbursed to a repatriate. Agencies are to evaluate the repatriates' needs for cash prior to issuing the check. In addition, costs associated with other expenses (e.g. transportation, temporary shelter, clothes) may be deducted from designated cash amount. Signed vouchers and/or copies of the paid check can serve as supporting documentation.

h. **Temporary Billeting/Shelter:** cost for temporary and reasonable shelter accommodation, whenever public shelters and/or other housing assistance programs are not available to the repatriates.

i. Vocational training: cost efficient expense used to assist the repatriate in obtaining certain minimum required job skills (e.g. GED). It does not cover long term education or college (including technical school) degrees. It is pre-approved by ACF.

j. Food: expenses associated with repatriate's temporary food supply.

k. Other: temporary assistance expense not listed above. Specify and provide supporting documentation.

l. Administrative: staff expenses directly associated with the provision of temporary services to eligible repatriates. Supporting statements (e.g. case workers' notes) and actual bills or receipts (e.g. parking receipt, taxi) must accompany the claim. Training and/or tips are not considered administrative costs.

12. Enter the name of the agency that will be receiving reimbursement from ACF. Provide reliable contact information for the person with authority to submit this claim on behalf of the agency. The signatory has the authority to certify that the state and/or service provider accepts responsibility for the correctness of the claim even though the expenditures were actually incurred by a different jurisdiction including a local jurisdiction of the state.

Document maintenance: case records, fiscal record supporting expenditures, including vendor bills invoices, vouchers, receipts, and cleared checks will be maintained by the agency and identified for audit purposes.

OMB Control No: 0970-0474
Expiration date: 04/30/2022

DEPARTMENT OF HEALTH & HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
330 C Street S.W., Washington D.C. 20201

U.S. REPATRIATION PROGRAM
PRIVACY AND REPAYMENT AGREEMENT FORM

☐ Check this box if you are completing and signing this form on behalf of the repatriate. Please know that the repatriate must sign this form unless he is a minor or an adult with a physical or mental condition that prevents him/her from signing this form. You must be an authorized representative in order to sign on behalf of the repatriate. Print the below information if you are signing on behalf of the repatriate:

Representative Name: *Relationship:* *Phone:*

Note: Providing the information on this form, including but not limited to the social security number, is voluntary. However, if you fail to provide the requested information, you may be found ineligible for repatriation assistance.

PRIVACY ACT STATEMENT

I, (print repatriate's name)_____, authorize the Department of Health and Human Services (HHS), U.S. Repatriation Program (Program), to collect and have access to my protected health information (PHI) and to disclose my PHI to other Federal, State or private organizations, if necessary to enable the HHS to carry out its responsibilities under 42 U.S.C. 1313 and 24 U.S.C. Sections 321 through 329, or to enable another Federal agency to carry out any functions related to my return from a foreign country and entry into the United States, or as otherwise expressly authorized by appropriate HHS staff.

ACCEPTANCE OF REPATRIATION SERVICES AND REPAYMENT AGREEMENT

I understand that all financial, medical, transportation and other temporary assistance provided to me through the Program must be repaid, unless a waiver is granted by authorized HHS officer. I understand that I will be billed by the HHS directly or through its designee 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 U.S. 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 HHS at 330 C Street S.W., Washington D.C. 20201, Attention: U.S. Repatriation Program.

Repatriate's Name (print) Last _____ First/MI_____

Address:_____
Street City State Zip Code

Repatriate 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 above is correct. **All payments must be sent to** HHS**-** Program Support Center, Accounting Services – Debt Collection Center, 7700 Wisconsin Avenue, Suite 8-8110D, Mail Stop 1023B,
Bethesda, Maryland 20857 (Zip Code 20814 for UPS/FEDEX Mail). Email: PSCDebtServicing@psc.hhs.gov Telephone: 301-492-4664

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Signature:	**Date:**

OMB Control No: 0970-0474
Expiration date: 04/30/2022

DEPARTMENT OF HEALTH & HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
330 C Street S.W., Washington D.C. 20201

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 content. 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. A representative (spouse, guardian, and/or legal representative) may ordinarily sign on his/her behalf.

Introduction: The U.S. Repatriation 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 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 the box indicating whether you are the authorized representative or repatriate.

Repatriate ☐ Authorized Representative ☐

Type Name: _____ _____
DOB

Signature: _____ _____
Date

Witness: _____ _____
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.