



# REPATRIATION/EMERGENCY MEDICAL AND DIETARY ASSISTANCE LOAN APPLICATION

<b>PART 1 - APPLICATION TO BE COMPLETED BY EACH ADULT APPLICANT REGARDLESS OF NATIONALITY</b>								
1. Last Name <i>(Print Clearly)</i>			2. First Name			3. Middle Name		
4. Social Security Number		5. Date of Birth <i>(DD-MMM-YYYY)</i>	6. Place of Birth		7. Identity Document Issuing Country _____ Passport No. _____ OR National ID No. _____		8. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
9. Current lodging where you may be contacted now								
10. Phone number where you may be contacted now				11. Email address where you may be contacted now				
12. Medical condition, current injuries, or limited mobility relevant to evacuation								
<b>13. Verifiable Billing Address at Final Destination in United States or other Permanent Address (Not a Post Office Box)</b>								
14. Address Line 1								
15. Address Line 2								
16. City			17. State/Province			18. Country		
19. Postal Code		20. Telephone Number <i>(Include Country/City Codes)</i>			21. Email Address			
<b>22. Emergency Contact (Do not list someone traveling with you)</b>								
23. Last Name <i>(Print Clearly)</i>				24. First Name				
25. Address Line 1								
26. Address Line 2								
27. City			28. State/Province			29. Country		
30. Postal Code		31. Telephone Number <i>(Include Country/City Codes)</i>			32. Email Address			
33. Relationship to you								
<b>34. Minor Children or Incapacitated/Incompetent Adults to be Repatriated or to Receive Emergency Medical and Dietary Assistance, list below.</b> <input type="checkbox"/> Check here if none								
35. Last Name <i>(Print Clearly)</i>			36. First Name			37. Middle Name		
38. Social Security Number		39. Date of Birth <i>(DD-MMM-YYYY)</i>	40. Place of Birth		41. Identity Document Issuing Country _____ Passport No. _____ OR National ID No. _____		42. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	43. This Person is My:
44. Last Name <i>(Print Clearly)</i>			45. First Name			46. Middle Name		
47. Social Security Number		48. Date of Birth <i>(DD-MMM-YYYY)</i>	49. Place of Birth		50. Identity Document Issuing Country _____ Passport No. _____ OR National ID No. _____		51. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	52. This Person is My:

53. Last Name <i>(Print Clearly)</i>		54. First Name		55. Middle Name	
56. Social Security Number	57. Date of Birth <i>(DD-MMM-YYYY)</i>	58. Place of Birth	59. Identity Document		60. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
			Issuing Country		
			Passport No.		61. This Person is My:
			OR National ID No.		
62. Last Name <i>(Print Clearly)</i>		63. First Name		64. Middle Name	
65. Social Security Number	66. Date of Birth <i>(DD-MMM-YYYY)</i>	67. Place of Birth	68. Identity Document		69. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
			Issuing Country		
			Passport No.		70. This Person is My:
			OR National ID No.		
71. Last Name <i>(Print Clearly)</i>		72. First Name		73. Middle Name	
74. Social Security Number	75. Date of Birth <i>(DD-MMM-YYYY)</i>	76. Place of Birth	77. Identity Document		78. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
			Issuing Country		
			Passport No.		79. This Person is My:
			OR National ID No.		
80. Last Name <i>(Print Clearly)</i>		81. First Name		82. Middle Name	
83. Social Security Number	84. Date of Birth <i>(DD-MMM-YYYY)</i>	85. Place of Birth	86. Identity Document		87. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
			Issuing Country		
			Passport No.		88. This Person is My:
			OR National ID No.		
<b>89. PART 2 - Promissory Note and Repayment Agreement</b>					
<p>1. I promise to repay the U.S. Government in U.S. dollars or the foreign currency equivalent, within 30 days of initial billing, and if not repaid within 60 days of initial billing at an interest rate established in accordance with Federal law, for Emergency, Medical and Dietary Assistance or Repatriation loans. This loan is in addition to any other U.S. Government loans received for other purposes. I will keep the Department of State's Accounts Receivable Branch informed of my address(es) until I repay my loan in full. If I am unable to pay this loan in full, the Department of State may, at its discretion and upon my request, forward to me an installment agreement containing an installment plan for repayment of my loan.</p> <p>2. I understand that:</p> <p>(a) My obligation to repay my loan will not be considered paid in full until it clears through the account of the Treasurer of the United States.</p> <p>(b) Until I have paid my loan in full, I and all listed U.S. citizen family members will only be eligible for a limited validity U.S. passport.</p> <p>(c) If my loan is in default, I and all U.S. citizen listed family members will not be eligible for limited validity U.S. passports.</p> <p>(d) My loan will be subject to interest, penalties, and other charges for late payment as directed by law and regulation.</p> <p>(e) I will be liable to pay any costs for collection.</p> <p>3. I will include my name, date of birth, place of birth, and Social Security number with all correspondence, payments, and questions. I will make payment to the Department of State, Accounts Receivable by credit/debit card, check or money order payable to Accounts Receivable Branch, PO Box 979005, St. Louis, MO 63197-9000. (Send questions by mail to: Accounts Receivable Branch, Global Financial Services, Department of State, PO Box 150008, Charleston, SC 29415-5008. Send questions by courier (DHL, Fedex, UPS, etc.) to: Accounts Receivable Branch, Global Financial Services 1969 Dyess Ave., Building 646-B, North Charleston, SC 29405. To make inquiries by telephone: From the U.S. or Canada, call: 1-800-521-2116 or internationally, call 843-746-0592. To make inquiries by email, contact: FMPARD@state.gov.)</p> <p>4. I understand that assistance requested from the Department of Health and Human Services (HHS) will be provided based on availability upon arrival in the United States. In addition, reception and resettlement assistance provided by HHS is in the form of a loan which has to be paid back to the U.S. Government.</p>					
<b>90. Signature Block for Applicant</b>					
I hereby accept the foregoing terms and conditions of repayment for myself and persons listed.					
91. Full Name Printed _____					
92. Signature _____			93. Date <i>(DD-MMM-YYYY)</i> _____		

**94. AUTHORIZATION FOR RELEASE OF INFORMATION UNDER THE PRIVACY ACT**

*The Privacy Act authorization is optional and will not affect the Department of State's processing of your loan application.*

I authorize the Department of State, including U.S. diplomatic and consular missions, to release information about me and persons listed to: (Please place a check in the following boxes for the people to whom you authorize information to be released.)  family,  friends,  individual members of congress,  members of the press,  and the general public.

95. Signature \_\_\_\_\_ 96. Date (DD-MMM-YYYY) \_\_\_\_\_

97. I authorize the Department of State to provide information to the U.S. Department of Health and Human Services (HHS) (Repatriation Program) and/or its partners and grantees with information to assist in my/our resettlement if needed.

98. Signature \_\_\_\_\_ 99. Date (DD-MMM-YYYY) \_\_\_\_\_

100. If form is signed before Notary Public in the United States for benefit of unaccompanied minor child or inconpacitated or incompetent adult abroad.

State of \_\_\_\_\_ County of \_\_\_\_\_ On \_\_\_\_\_, before me \_\_\_\_\_  
Date (DD-MMM-YYYY) \_\_\_\_\_ (Notary)

Personally appeared, \_\_\_\_\_ Notary Public for My Commission Expires \_\_\_\_\_  
(Signer)

**PART 3 - CONSULAR NOTES - For Official Use Only**

- No Signature of Loan Recipient - Minor
- No Social Security Number
- No Signature of Loan Recipient - Incapacitated/Incompetent Adult
- Escort (No Familial Relationship)
- Loan Includes Temporary Subsistence
- Other (Please Explain)

If applicable, list U.S. citizen associated with Third Country National/Host Country National, accompanying spouse or partner, or escort of primary applicant.

Name of the U.S. Citizen	Date of Birth	Place of Birth	Social Security Number
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**Repatriation to United States or Emergency Medical or Dietary Assistance Abroad (EMDA) Loan Amount**

Amount in Foreign Currency \_\_\_\_\_ Amount in U.S. Currency \_\_\_\_\_

The above total includes U.S. Dollars currency for subsistence for the following dates: \_\_\_\_\_ and U.S. Dollars currency for Repatriation/Emergency Medical and Dietary Assistance.  
From (mm-dd-yyyy) \_\_\_\_\_ To (mm-dd-yyyy)

**PART 4 - CONSULAR OFFICER SIGNATURE AND CERTIFICATION**

The undersigned consular officer approves the loan specified above and certifies the persons listed boarded the transport.

\_\_\_\_\_  
Signature of Consular Officer Name of Post

\_\_\_\_\_  
Typed or Printed Name of Consular Officer Date (DD-MMM-YYYY)

\_\_\_\_\_  
Title of Consular Officer **SEAL**

**PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENT**

**AUTHORITY:** The information on this form is requested under the authority of 22 U.S.C. §§ 2670, 2671 and E.O. 9397, as amended.

**PURPOSE:** The principal purpose of the information gathered is to provide an accurate list of U.S. citizens and non-U.S. citizens receiving repatriation/emergency medical and dietary assistance in foreign countries.

**ROUTINE USES:** The information solicited on this form may be made available to other government agencies to assist the U.S. Department of State in processing repatriation/emergency medical and dietary assistance documentation and related services, law enforcement and administrative purposes. More information on the Routine Uses for the system can be found in System of Records Notice, State-05, Overseas Citizens Services Records and the Prefatory Statement of Routine Uses published in the Federal Register.

**DISCLOSURE:** Furnishing the requested information is voluntary, but failure to provide it may result in delays in reviewing the application or in an inability to provide the requested assistance.

**PAPERWORK REDUCTION ACT (PRA) STATEMENT**

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: CA/OCS/L, 4th Floor, SA-29, U.S. Department of State, Washington, DC 20522-2202.