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DEPARTMENT OF HEALTH & HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES
370 L'Enfant Promenade, S.W., Washington, D.C. 20447

U.S. REPATRIATION PROGRAM
PRIVACY ACT STATEMENT 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: Furnishing 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 370 L'Enfant Promenade SW, Washington, DC 20447, or 202-401-9246. 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 PSC/HHS**: U.S. Repatriation Program, Attention: Repatriation Collections Office, 2501 Ardennes Ave, Suite 100, Rockville, MD 20857. Tel: (301) 443-9250.

Signature:	**Date:**

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