



**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:

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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.