OMB Control No: 0970-0474
Expiration date: 03/31/2019

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

U.S. REPATRIATION PROGRAM

Repatriation Loan Waiver and Deferral Request Form

Submitted for Government Action on Claims due the United States
(NOTE: Use additional pages where space on this form is insufficient or continue on reverse side of pages)

Instruction and Information: This form is to be completed by individuals who have received temporary assistance through the United States (U.S.) Department of Health and Human Services (HHS) Repatriation Program, and want to request a waiver or deferral of their repatriation loan. In addition, this form can be completed by:

- Adults applying on behalf of themselves and dependents;
- Adult representative of a minor child (parent, guardian, or legal representative);
- Adult representative of a mentally or physically impair adult.

The U.S. Repatriation Program may perform an investigation and at its discretion to determine whether to waive the whole or any portion of a repatriation loan. In addition, it may grant a deferral instead of a waiver if it is determined that the prospects of future collection are promising enough to justify periodic review of the debt. Eligibility determinations are made by the Administration for Children and Families (ACF) in accordance to 45 CFR 211.13 and 212.7.

This form must be submitted to the U.S. Repatriation Program at the address listed at the top of this form. The application must contain necessary supporting documentation. For more information or to obtain an electronic copy of this form, please visit the U.S. Repatriation Program website at: http://www.acf.hhs.gov/programs/orr/programs/repatriation.

DO NOT complete this form if you are looking for a payment plan. For inquiries related to your loan collection and payment plan, please contact the HHS-Program Support Center at: 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

Authority for the solicitation of the requested information is one or more of the following: 24 U.S.C. §§ 321-329 and 42 USC 1313; 45 CFR Parts 211 and/or 212. Use additional sheets, with your name listed on the left hand corner, where space on this form is insufficient. The principal purpose for gathering this information is to evaluate and substantiate your capacity to repay your U.S. Repatriation Loan. Disclosure of information requested on this form, including but not limited to the social security number, is voluntary. If the requested information is not furnished, the Government will pursue immediate and full payment of your repatriation loan.

Please contact ACF immediately if there are any changes to the information provided on this form.

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13): Public reporting burden for this collection of information is estimated to average 0.30 hour 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.

PART I: REPATRIATE INFORMATION

1. **I am requesting (select one)**: **Waiver** ☐ **Deferral** ☐

1. Name *(Repatriate)*	2. Birth Date (DD/MM/YYYY)
3. Home Address (Street–City–State–Zip) This address is ☐ Permanent ☐ Temporary?	4. Phone/e-mail:
5. Name of Spouse/Legal Guardian *(give address if different from yours)*	6. Date of Birth (DD/MM/YYYY)

2. **Number of individuals included in this application**:__________ Complete the table below for each waiver/deferral applicant.

Last Name	First Name	DOB (DD/MM/YYYY)	Social Security Number	Relationship
				Self

PART II: PUBLIC ASSISTANCE

Complete the table below if you are receiving and/or are expecting to receive public assistance. Provide documentation whenever applicable (e.g. copy of SSI eligibility letter).

Applicant's name	Type of assistance applied for (E.g. TANF, SSI, Medicaid, Section 8)	Date application was submitted	Application Status: Pending, Approved, denied, other	Date application was accepted	Amount receiving or expecting to receive
Self					

PART III: REPATRIATE EMPLOYMENT AND INCOME INFORMATION

1. **Are you able to work?** ☐ **YES:** complete information below ☐ **NO:** If your answer is no, please provide a written explanation or documentation whenever applicable (e.g. doctor's note, SSI eligibility letter).

Occupation		How Long in Present Employment?
Present Employer's Name	Address	Phone No

2. **Legal guardian employment information:** Complete this section if ing out this form on behalf of a minor or mentally/physically impaired adult

Occupation		How Long in Present Employment?
Present Employer's Name	Address	Phone No.

3. Household Monthly Income: Complete the table below and include the total amounts per household. Provide documentation whenever applicable (e.g. paystubs).

Name	Salary or Wages $	Income received from or for the dependent (e.g. child support, SSI) ($)	Other income (e.g. rent) $

4. Assets: List all assets (both in the U.S. and overseas) and total amount per asset owed by the individual(s) requesting this waiver/deferral.

Assets	Total amount ($)	Year received or expected to receive
Personal property in excess of $1,500		
All transfers and/or sells (e.g. gift, loan) made within the last 3 years from which you made a profit of $1,500 or more		
Other: please specify		
Other: please specify		

PART V: FIXED MONTHLY EXPENSES AND LIABILITIES:

Complete the information below if you are paying out of pocket and no assistance is received to cover these costs. For instance, you should not include your medical bills if they are covered by your medical coverage. However, the amount that you are responsible for should be included. For example, if the medical bill is $2,000 and you are responsible for 10% of the bill, the amount you will list is $200.

Expenses and Liabilities	Monthly payment	Total amount currently owed
Food		
Rent		
Mortgage: If different from rent		
Utilities		
Transportation		
Hospitals/Doctors/prescription		
Lawyer		
Car		
Furniture		
Clothes		
Taxes owed		
Insurance: Specify		

Credit cards		
Child support		
Other Loans: Specify		
Other: Specify		
Total per month $		

PART X: GENERAL QUESTIONS

Answer each question by checking the Yes or No selection. For every question marked **"Yes"** you must provide an explanation in the space provided below.

Questions	Yes	No
1. Are you a party of any pending lawsuit?		
2. Do you have any claims from which you expect to receive any income or resources? Claims against any individual, trust or state, partnership, corporation, or government?		
3. Do you have any claims against any individual, trust, partnerships, corporations, or government?		
4. Are you a trustee, executor, or administrator of any estate?		
5. Is there anybody holding money on your behalf?		
6. Will you receive or inherit any financial assets within the next two years?		
7. Do you receive or expect to receive benefits from any established trust, claim for compensation or damages, contingent on future interest in property of any kind?		
8. Do you receive or expect to receive federal, state, or local cash refund?		

Below, provide an explanation to all YES answers in Part X. Use additional pages, if needed.

a material fact; **(2)** makes any materially false, fictitious, or fraudulent statement or representation; or **(3)** makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years…or both"

Applicant Signature: ______________________________ **Date:** ____________________

Signature: Repatriate should sign this form unless he/she is a minor or an adult with a mental or physical condition medically prevents them from signing this form.