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
Temporary Assistance and Extension Request Form

(NOTE: Use additional pages where space on this form is insufficient or continue on reverse side of pages)

INSTRUCTIONS: Please complete ONE FORM per individual or nuclear family. Include extra pages if space is not sufficient to provide the requested information. Please WRITE the applicant's name on the right hand corner of each additional page.

Who is eligible? Individuals with an open repatriation case with the Department of Health and Human Services (HHS) who are determined to be handicapped in attaining self-support or self-care for such reasons as age, disability, and lack of educational preparation as defined by 45 CFR 211 & 212. Applicants must submit this form with all applicable supportive evidence. Final eligibility determinations are made by authorized HHS Repatriation Program staff. Timely submission is highly recommended, at least two weeks prior to the last eligibility date. Applications submitted after the eligibility period may not be reviewed and will generally result in ineligibility. Failure to provide all supportive documents may result in denial and/or delays. No retroactive services are provided through this program.

Who should complete this form? Below is a list of who can sign this form:

- Only those who fall within the above question 1
- Adults applying for themselves
- 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 impaired adult

Disclaimer: The statutory authority for this collection is 42 U.S.C. Section 1313 and 24 U.S.C. Sections 321 through 329, and the Health Insurance Portability and Accountability Act of 1996. Information solicited on this repatriation form is for the purpose of determining your eligibility for and extension of temporary assistance under the U.S. Repatriation Program. 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.

Personal information provided on this form may only be disclosed for Program purposes or under the conditions prescribe in 45 CFR 211.14 or 45 C.F.R.212.9.

Title 18 of the United States Code 1001 states that an individual who "knowingly and wilfully - **(1)** falsifies, conceals, or covers up by any trick, scheme, or device 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"

The Paperwork Reduction Act of 1995 (Pub. L. 104-13): Public reporting burden for this collection of information is estimated to average 0.3 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.

Today's Date: ___/___/___

Repatriate's Name: _____

1. **Repatriation Case Number** (If you do not have this information, please contact your designated repatriation worker for assistance): #_____

2. **Number of eligible individuals included in this request: _____. Please complete the below table.**

Name (First, Middle, Last)	Social Security Number	DOB (DD/MM/ YYYY)	Individual is applying for assistance (Y/N)	Relationship to Repatriate
1- Self				
2				
3				
4				
5				

3. **Who is requesting this extension? Please check ONE**

If this request is not submitted by the repatriate, please provide documentation showing that the repatriate has authorized you to act on his/her behalf (e.g. notarized letter) and/or that you have authority to submit this request on behalf of the repatriate/s (e.g. explanation letter).

☐ **Adult repatriate**

☐ **Adult repatriate applying for self and dependents**

☐ **State representative**

☐ **Adult representative of a minor child (parent, guardian, or legal representative)**

☐ **Adult representative of a mentally or physically impaired adult**

4. **Reason for the Extension Request:** Check the boxes that apply to your claim of being handicapped in attaining self-support or self-care.

☐ Age

☐ Disability

☐ Lack of vocational preparation

☐ Other reasons (specify):

Written explanation: Please provide a written explanation below for each of the above selected reasons for the extension request**.** Use additional paper if needed. Write your name and case number on the left hand side of each additional page. In addition**,** attach all applicable supporting documentation to substantiate your claim. For example, if claiming disability, supportive documents may include a letter from your medical provider indicating your disability.

5. **Financial and other Services:**

   a. Are you working? ☐ Yes ☐ No

   b. What is your household monthly combined income? $ _____

   c. Are you a party of any pending lawsuit? ☐ Yes ☐ No

   d. Do you own any assets either in the U.S. or overseas (e.g. houses, stocks, land)? If yes, provide the estimated total amount.

      ☐ Yes: $_____ ☐ No

6. **Available Services:** Complete the below table if you are receiving and/or are expecting to receive public assistance.

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					

Applicant Signature: _____ Date:_____