

## U.S. REPATRIATION PROGRAM TEMPORARY ASSISTANCE EXTENSION REQUEST

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to request an extension for temporary assistance under the U.S. Repatriation Program beyond the initial 90-day eligibility period. Public reporting burden for this collection of information is estimated to average 0.3 hours per respondent, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This collection of information is required to request an extension for temporary assistance (42 U.S.C. Section 1313). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0474 and the expiration date is **XX/XX/XXXX**. If you have any comments on this collection of information, please contact the U.S. Repatriation Program, 330 C St. SW, Washington, D.C. 20201.

<b>SECTION I: REPATRIATE INFORMATION</b>			
1. Last Name	2. First Name	3. Middle Name	
4. Case Number	5. Social Security Number	6. Date of Birth	7. Date of Request (MM/DD/YYYY)

<b>SECTION II: DEPENDENT INFORMATION</b>		
8. Enter dependent information. If more than 5, use a separate sheet of paper.		
Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Relationship to the Repatriate
1 -		
2 -		
3 -		
4 -		
5 -		

<b>SECTION III: JUSTIFICATION</b>
9. Reason for 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
10. Additional Comments.

**SECTION IV: ELIGIBILITY**

**11. Self-Assessment**

a. Are you working?	Yes	No
b. Are you a party of any pending lawsuit?	Yes	No
c. 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
	\$ _____	

**12. Benefits. Complete the below table if you are receiving and/or are expecting to receive public assistance.**

Name (Last, First, Middle Initial)	Type of Assistance Applied For (e.g. TANF, SSI, Medicaid)	Application Submission Date (MM/DD/YYYY)	Application Status: Pending, Approved, Denied, Other	Date Application was Accepted	Amount Receiving or Expecting to Receive
1 - SELF					
2 -					
3 -					
4 -					
5 -					
6 -					
<b>Total</b>					

**13. Additional Information**

**14. Monthly Household Income**

Last Name	First Name	Salary or Wages in \$	Type of Income Received (e.g., child support, SSI, etc.)	Other Income

**15. Present Monthly Combined Household Income**

Salary or Wages \$ \_\_\_\_\_ Other (assistance) \$ \_\_\_\_\_ **Total: \$ \_\_\_\_\_**

**16. Fixed Monthly Expenses**

Fixed Monthly Expenses	Monthly Payment
Rent	
Utilities	
Food	
Transportation (e.g., public or ride-share)	
Household	
Lawyer / Legal Expenses	
Insurance	
Medical Costs	
<b>Total</b>	

17. Loans and Liabilities	Monthly Payment	Total Amount Currently Owed
Mortgage (if different from rent)		
Car		
Lawyer/ Legal Expenses		
Furniture		
Taxes Owed		
Loans Payable (to banks, finance company, etc.)		
Credit Card(s)		
Child Support		
Other Loans and Debt (please specify):		
Other Loans and Debt (please specify):		
<b>Total</b>		

<b>SECTION V: APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE</b>	
<p><i>By signing this document, I certify that it is true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil or administrative penalties. (U.S. Code, Title 18, section 1001)</i></p>	
18. Signature of Applicant or Authorized Representative	19. Date (MM/DD/YYYY)

<b>SECTION VI: AUTHORIZED REPRESENTATIVE INFORMATION (IF APPLICABLE)</b>		
20. Representative Last Name	21. Representative First Name	22. Representative Middle Name
23. Relationship	24. Phone Number	25. Email Address

## **GENERAL INFORMATION**

**Purpose:** Individuals currently receiving temporary assistance through the U.S. Repatriation Program, who are handicapped in attaining self-support or self-care due to age, disability, or lack of vocational preparation, may use this form to request an extension for the eligibility period beyond the initial 90-day period per 45 CFR 212.4.

**Who Should Complete this Form:** 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); or
- Adult representative of a mentally or physically impaired adult.

**When to Submit:** Extension requests must be submitted no later than 30 days prior to the end of the current eligibility period.

**Where to Submit:** This form, and all supporting documents, should be provided to ISS-USA, 1120 N. Charles St., Suite 300, Baltimore, MD 21201.

**Disclaimer:** Title 18 of the United States Code 1001 states that an individual who “knowingly and willfully - (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.”

## **SPECIFIC INSTRUCTIONS**

### **SECTION I: REPATRIATE INFORMATION**

**Item 1. Last Name.** Provide your last name.

**Item 2. First Name.** Provide your first name.

**Item 3. Middle Name.** Provide your middle name. If no middle name, write “NMN.”

RR-07

**Item 4. Case Number.** Provide your case number. (If you do not have this information, please contact your designated repatriation worker for assistance).

**Item 5. Social Security Number.** Provide your nine-digit social security number.

**Item 6. Date of Birth.** Provide your date of birth. Format as two-digit day and month and four-digit year.

**Item 7. Total # of Repatriates Included in the Request.** Include yourself and any dependents included in the original application (Form RR-05). Complete the table.

### **SECTION II: DEPENDENT INFORMATION**

**Item 8. Enter dependent information.** Provide full name(s) and date(s) of birth of your dependent(s), and their relationship to you (e.g., disabled parent, minor child, etc.)

### **SECTION III: JUSTIFICATION**

**Item 9. Reason for Extension Request.** Check all boxes that apply. Provide a written explanation in the space provided for each of the selected reasons for the extension request. Use additional paper if needed. 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.

**Item 10. Additional Information.** Use this space to provide any further background.

### **SECTION IV: ELIGIBILITY**

**Item 11. Self-Assessment.** Fill out all line items a-c.

**Item 12. Benefits.** For each repatriate receiving services under the U.S. Repatriation Program, indicate what type(s) of other federal or state government assistance they are receiving or expect to receive, and the amount of the benefit, in addition to the application submission and acceptance dates, and the status of the application. Provide a total in the last row.

**Item 13. Additional Information.** Use this space to provide any further background.

**Item 14. Monthly Household Income.** For each member of your household generating an income, fill out a row and provide details for each column.

**Item 15. Present Monthly Combined Household Income.** Combine your income and members of your household's income in the space provided.

**Item 16. Fixed Monthly Expenses.** Provide the monthly payment in the spaces provided for each row. Provide a total in the last row.

**Item 17. Loans and Liabilities.** Provide the monthly payment and total amount currently owed in the spaces provided for each row. For example, you have a monthly medical payment of \$150, and the total amount due is the remaining balance, which is \$500. Provide the totals in the last row.

#### **SECTION V: APPLICANT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**Item 18. Signature of Applicant or Authorized Representative.** The repatriate applicant or authorized representative must sign here to process the extension request.

**Item 19. Date (MM/DD/YYYY).** Provide today's date. Format as two-digit day and month and four-digit year.

#### **SECTION VI: AUTHORIZED REPRESENTATIVE INFORMATION (IF APPLICABLE)**

**Item 20. Last Name.** Provide the representative's last name.

**Item 21. First Name.** Provide the representative's first name.

**Item 22. Middle Name.** Provide the representative's middle name. If no middle name, write "NMN."

**Item 23. Relationship.** Indicate the relationship of the authorized representative filling out the form to the U.S. citizen applicant. Example: parent, legal guardian.

**Item 24. Phone Number.** Enter the primary phone number, including area code, to communicate with you regarding the repatriate's temporary assistance extension request.

**Item 25. Email Address.** Enter the primary email address to communicate with you regarding the repatriate's temporary assistance extension request.

