

Department of Health and Human Services
Employee Emergency Payment Request
Promissory Repayment Agreement, and Salary Offset Authorization

1. I, _____, certify that I have not received my salary for the pay period ending _____ because _____

I request an emergency payment of \$ _____

2. I understand that I am personally liable for repaying the Federal Government. *I agree to make full repayment within thirty (30) days of the date that the Employee Emergency Payment is issued.* Repayment can be made by cash, check, or check, or money order made payable to the "National Institutes of Health, HHS" and delivered to: HHS, NIH, Operations Accounting Branch, Building 31, Room B1B31, Bethesda, Md. 20892.

3. I understand my failure to repay this emergency payment timely and in full subjects me to late payment interest charges, administrative costs, and penalties (in addition to the actual emergency payment amount); and other collection actions as authorized by the Debt Collection Act of 1982 implemented by 45 CFR Part 30 and 5 CFR Part 550. Payment is considered timely only if full repayment is received in the Operations Accounting Branch, NIH, within thirty (30) days of the date that the Employee Emergency Payment is issued. I also understand that: (a) Interest is assessed at the Private Consumer Rate, that is in effect on the date the Employee Emergency Payment is issued. Interest is assessed on thirty (30) day periods. A partial period is considered a full period. (b) Administrative costs of \$20.00 are charged for each full or partial thirty (30) day period that repayment is late. (c) An additional late charge penalty of six percent (6%) is charged on repayments which are more than ninety (90) days late. (d) Delinquent accounts can be reported to consumer credit bureaus which will affect my credit rating; private collection agencies whose fee is an additional administrative cost charge; and the Department of Justice for suit in Federal court. (e) Delinquent accounts are subject to recovery by withholding the amounts owed from my salary, retirement fund, and/or any other funds due me.

4. I have read and understand the above and request an Employee Emergency Payment. I further understand that I must make full repayment within thirty (30) days and I hereby authorize the National Institutes of Health, HHS, to initiate payroll offset with the payroll office or offset any other funds due me for all or any part of the Employee Emergency Payment contained in the Promissory Repayment Agreement that has not been repaid within thirty (30) days of the date issued, to include all applicable interest, administrative costs, and penalty charges as described above without further notice to me.

Employee's Signature Date ICD, Division, Branch Bldg./Rm. Phone No.

Current Home Address: _____

Prior Home Address: _____
(Fill out only if address has recently changed)

Emergency Payment Request Date: _____

(Continued on back)

Department of Health and Human Services
Employee Emergency Payment Request
Promissory Repayment Agreement, and Salary Offset Authorization

(Back)

This information is completed by your supervisor, administrative officer, and the Chief, Payroll Operations Section, DPM

Supervisor: I certify that the above employee has indicated to me that he/she did not receive his/her regular salary payment.

| | | | |
|------------------------|------|-----------|-----------|
| Supervisor's Signature | Date | Bldg./Rm. | Phone No. |
|------------------------|------|-----------|-----------|

Chief, Payroll Operations Section and Administrative Officer:

| | |
|-----------------------|---------------------------------|
| Employee's SSN: _____ | Net Amount of Salary Chk: _____ |
| Timekeeper No: _____ | Retirement Balance: _____ |
| Approp/CAN No: _____ | Annual Leave Balance: _____ |

| | | | |
|--------------------------------------|------|------------------------|------|
| Chief, Payroll Operations Section | Date | Administrative Officer | Date |
|--------------------------------------|------|------------------------|------|

Finance Office Approval:

I hereby authorize the amount of \$ _____ as an emergency payment.

| | |
|--------------------------------------------------------------------------------------------------------|------|
| Chief, Disbursing Services Section Operations Accounting Branch Division of Financial Management | Date |
|--------------------------------------------------------------------------------------------------------|------|

Privacy Act Statement

The primary use of this information is by management and your payroll office to account for payroll compensation and leave usage. Additional disclosures of the information may be to: the Internal Revenue Service and to state and local government agencies having taxing authority; a Federal, State, or local law enforcement agency when the Department becomes aware of a violation or possible violation of civil or criminal law; a Federal agency when conducting an investigation on you for employment or security reasons; the Office of Personnel Management or General Accounting Office when the information is required for evaluation of leave administration; a contractor for the purpose of collating, analyzing, aggregating or otherwise refining records; the Department of Treasury for the purpose of preparing and issuing employee salary and compensation checks and U.S. Savings Bonds; and the General Services Administration in connection with its responsibilities for records management.

If this information is used for purposes other than these indicated above, the Department may provide you with an additional statement reflecting those purposes.

Executive Order 9397 authorizes collection of your Social Security Number (SSN) and requires the mandatory use of the SSN as an identifier in a system of records concerning financial matters and related transactions with individual employees.