UNITED STATES COAST GUARD
SPECIAL NEEDS PROGRAM
ENROLLMENT FORMS

RETURN COMPLETED FORMS TO:

United States Coast Guard
Family Resource Specialist
ATTN: May Chao-Higginbotham
1519 Alaskan Way S.
Seattle, WA 98134

If you desire to send forms by encrypted password protected email, please forward to:
May.chaohigginbotham@uscg.mil

For questions, please contact me at
(206)217-6786
or at the email address listed above.

Tips for Completing Special Needs Enrollment/Disenrollment Forms

Members/Family Members

- Complete pages 1 and 2 of DD Form 2792
  - Adult family members (i.e., spouses and adult children) with Special Needs MUST sign the consent form on page 1
  - Either the sponsor or the adult family member MUST sign on page 2, item 6a.
  - Write in "USCG" for Branch of Service (Item 3d on page 2)

- Have your primary provider complete pages 4-7 and any necessary addendums

  Educational Special Needs ALSO require the completion of DD Form 2792-1

  - Members/family members complete page 2, items 1-7, and page 3, items 1-2 only
    - Sponsor or spouse MUST sign page 2, item 7a
    - Sponsor or spouse MUST sign page 3, item 1a

  - Have your official school personnel complete page 3, items 3-8

IMPORTANT: Provider Appointments

1. Schedule an "Office Visit" with a Tricare Provider (Standard or Prime) for completion of the DD-2792 Form, Family Member Medical Summary. Walk-ins are NOT authorized.

2. If you or your Tricare Provider has questions regarding Tricare authorization for completing DD-2792 form, contact the regional Tricare office:

   - North Region 877-874-2273
   - South Region 800-444-5445
   - West Region 888-874-9378

3. You should NOT be billed for the "Office Visit" related to the completion of the DD-2792. In the unlikely case that you are billed, complete DD Form 2642, Tricare Medical Claim, Patient's Request for Medical Payment – http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2642.pdf.

SPECIAL NEEDS PROGRAM
POLICY UPDATE: ALCOAST 400/11

R 241558Z AUG 11

ALCOAST 400/11
COMDTNOTE 1754
SUBJ: SPECIAL NEEDS PROGRAM POLICY UPDATES

1. THIS ALCOAST ESTABLISHES SPECIAL NEEDS PROGRAM POLICY THAT WILL BE INCORPORATED INTO THE REVISION OF REFERENCE (A). THE POLICY BECOMES EFFECTIVE ON 1 OCTOBER 2011, WITH FULL COMPLIANCE EXPECTED BY 1 JANUARY 2012.

2. THE SPECIAL NEEDS PROGRAM IS A MANDATORY ENROLLMENT PROGRAM FOR ALL ACTIVE DUTY (AD) AND SELECTED RESERVE MEMBERS ON ORDERS FOR 180 DAYS OR MORE (HEREINAFTER REFERRED TO AS AD MEMBERS) WHO HAVE DEPENDENT FAMILY MEMBERS DIAGNOSED WITH MEDICAL, PSYCHOLOGICAL, PHYSICAL, OR EDUCATIONAL SPECIAL NEEDS. THE OBJECTIVE OF THE PROGRAM IS TO IDENTIFY AND SUPPORT THE SPECIAL NEEDS OF A COAST GUARD FAMILY WHILE ALLOWING THE ACTIVE DUTY MEMBER TO MAINTAIN THE MAXIMUM ASSIGNMENT FLEXIBILITY POSSIBLE.

3. AD MEMBERS MUST ENROLL IN THE SPECIAL NEEDS PROGRAM IF THEY HAVE FAMILY MEMBERS WHO MEET ONE OR MORE OF THE FOLLOWING CONDITIONS:

A. MEDICAL SPECIAL NEEDS:
(1) MEDICAL CONDITIONS WHICH WOULD LIMIT THE WORLDWIDE ASSIGNMENT ABILITY OF AD MEMBERS (SUCH AS AUTISM, HIGH-RISK NEWBORNS, SICKLE CELL DISEASE, INSULIN-DEPENDENT DIABETES, HUMAN IMMUNODEFICIENCY VIRUS).
(2) MEDICAL CONDITIONS THAT REQUIRE MONITORING ON A PERIODIC BASIS DUE TO THE POTENTIAL OF LIMITING MEMBERS WORLDWIDE ASSIGNMENT (SUCH AS REMISSION OF CANCER WITHIN THE LAST 5 YEARS).
(3) POTENTIALLY LIFE-THREATENING MEDICAL CONDITIONS (SUCH AS HIGH RISK PREGNANCY, AIDS).
(4) DIAGNOSIS OF ASTHMA OR OTHER RESPIRATORY-RELATED DIAGNOSIS WITH CHRONIC RECURRING WHEEZING WHICH MEETS ONE OF THE FOLLOWING CRITERIA:
(A) SCHEDULED USE OF INHALED AND ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS.
(B) HISTORY OF EMERGENCY ROOM USE OR CLINIC VISITS FOR ACUTE ASTHMA EXACERBATIONS WITHIN THE LAST YEAR.
(C) HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA WITHIN THE PAST 5 YEARS.
(D) HISTORY OF INTENSIVE CARE ADMISSIONS FOR ASTHMA WITHIN THE PAST 5 YEARS.

B. PSYCHOLOGICAL SPECIAL NEEDS:
(1) CURRENT AND CHRONIC (DURATION OF 6 MONTHS OR LONGER) MENTAL

HEALTH CONDITION (SUCH AS BIPOLAR DISORDER, MAJOR DEPRESSIVE DISORDER, SUBSTANCE ADDICTION, AND/OR PERSONALITY DISORDERS).
(2) INPATIENT, OR INTENSIVE OUTPATIENT MENTAL HEALTH SERVICES WITHIN THE LAST 5 YEARS (SUCH AS DAY TREATMENT PROGRAM, COUNSELING PROVIDED AT FREQUENCY GREATER THAN 1 TIME PER WEEK, ETC).
(3) INTENSIVE (GREATER THAN ONE VISIT MONTHLY FOR MORE THAN 6 MONTHS) MENTAL HEALTH SERVICES REQUIRED AT THE PRESENT TIME (CONSISTING OF MEDICAL CARE FROM ANY PROVIDER, INCLUDING A PRIMARY HEALTH CARE PROVIDER).
(4) DIAGNOSIS OF ATTENTION DEFICIT DISORDER AND/OR ATTENTION DEFICIT HYPERACTIVITY DISORDER THAT MEETS ONE OF THE FOLLOWING CRITERIA:
(A) FAMILY MEMBER HAS ANY ADDITIONAL PSYCHOLOGICAL DIAGNOSIS.
(B) FAMILY MEMBER REQUIRES MULTIPLE MEDICATIONS, PSYCHO-PHARMACEUTICALS (OTHER THAN STIMULANTS) OR DOES NOT RESPOND TO
NORMAL DOSES OF MEDICATION.
(C) FAMILY MEMBER REQUIRES MANAGEMENT AND TREATMENT BY MENTAL HEALTH PROVIDER (FOR EXAMPLE, PSYCHIATRIST, PSYCHOLOGIST, AND/OR SOCIAL WORKER).
(D) FAMILY MEMBER REQUIRES A MENTAL HEALTH SPECIALTY CONSULTANT, OTHER THAN A FAMILY PRACTICE PHYSICIAN OR GENERAL MEDICAL OFFICER, MORE THAN TWICE A YEAR ON A CHRONIC BASIS.
(E) FAMILY MEMBER REQUIRES MODIFICATION OF THE EDUCATIONAL CURRICULUM OR THE USE OF BEHAVIORAL MANAGEMENT STAFF.

C. PHYSICAL SPECIAL NEEDS:
(1) FAMILY MEMBER REQUIRES ADAPTIVE EQUIPMENT FOR 6 MONTHS OR LONGER (SUCH AS AN APNEA HOME MONITOR, HOME NEBULIZER, WHEELCHAIR, SPLINTS, ORTHOTICS, HEARING AIDS, HOME OXYGEN THERAPY, HOME VENTILATOR, ETC).
(2) FAMILY MEMBER REQUIRES ENVIRONMENTAL AND/OR ARCHITECTURAL CONSIDERATIONS (SUCH AS LIMITED NUMBER OF STEPS, WHEELCHAIR ACCESSIBILITY AND/OR HOUSING MODIFICATIONS, AND AIR CONDITIONING).
(3) FAMILY MEMBER REQUIRES ASSISTIVE TECHNOLOGY DEVICES (SUCH AS COMMUNICATION DEVICES) OR SERVICES.

D. EDUCATIONAL SPECIAL NEEDS:
(1) CHILD (BIRTH THROUGH 2 YEARS OF AGE) HAS OR REQUIRES AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP).
(2) CHILD (3 THROUGH 21 YEARS OF AGE) HAS OR REQUIRES AN INDIVIDUALIZED EDUCATION PLAN (IEP).

4. SPECIAL NEEDS PROGRAM ENROLLMENT UPDATES FOR EACH FAMILY MEMBER ENROLLED IN THE PROGRAM ARE DUE EVERY 3 YEARS, NORMALLY WHEN THE MEMBER SUBMITS HIS/HER E-RESUME. EXCEPTIONS TO THIS TIMELINE (I.E., INSTANCES REQUIRING AN UPDATE) ARE AS FOLLOWS:
A. THERE IS A CHANGE IN MEDICAL OR MENTAL HEALTH RELATED DIAGNOSIS,
OR A NEW DIAGNOSIS DEVELOPS.
B. THERE IS A CHANGE IN EARLY INTERVENTION OR SPECIAL EDUCATION

NEEDS.
C. IF AN UPDATE IS DUE AT THE TIME OF A PROJECTED ROTATION DATE (PRD), IT MUST BE INITIATED AT LEAST 9 MONTHS PRIOR TO THE PRD.

5. DISENROLLMENT FROM THE SPECIAL NEEDS PROGRAM SHALL OCCUR WHEN ANY OF THE FOLLOWING SITUATIONS OCCUR:
A. IF SPECIAL MEDICAL, PSYCHOLOGICAL, SPECIAL ACCOMMODATIONS, OR EDUCATIONAL SERVICES ARE NO LONGER REQUIRED FOR A FAMILY MEMBER, AS VALIDATED BY A HEALTHCARE PROVIDER OR SCHOOL OFFICIAL. MEDICAL AND MENTAL HEALTH CONDITIONS MUST BE IN REMISSION FOR A MINIMUM OF 3 YEARS WITH NO MORE THAN ROUTINE PRIMARY CARE NEEDED.
B. IF THE DEPENDENT CHILD IS NO LONGER THE MEMBERS DEPENDENT, OR DOES NOT RESIDE WITH THE SERVICE MEMBER WHICH WOULD AFFECT HIS/HER AVAILABILITY FOR WORLDWIDE ASSIGNMENT, UNLESS ENROLLMENT IN SPECIAL NEEDS PROGRAM IS REQUIRED FOR A PROGRAM FOR WHICH THE DEPENDENT IS OTHERWISE QUALIFIED, SUCH AS TRICARE ECHO.
C. IN THE EVENT OF DIVORCE, LOSS OF CUSTODY, OR DEATH OF THE FAMILY MEMBER WITH SPECIAL NEEDS. BAH/DEPENDENCY STATUS IN DIRECT ACCESS WILL BE VERIFIED BY THE SERVICING HEALTH, SAFETY, AND WORK LIFE (HSWL) FAMILY RESOURCE SPECIALIST (FRS) TO CONFIRM DEPENDENCY INFORMATION. IN CASES INVOLVING CHILD CUSTODY ISSUES, A MEMO FROM A MEMBER SHALL BE FORWARDED TO THE HSWL FRS REQUESTING DISENROLLMENT FROM THE SPECIAL NEEDS PROGRAM. THE MEMO SHOULD INCLUDE THE FOLLOWING INFORMATION:
(1) FIRST AND LAST NAME OF THE FAMILY MEMBER WITH SPECIAL NEEDS AND HIS/HER RELATIONSHIP TO THE SPONSOR.
(2) TYPE OF DOCUMENT CITED (DIVORCE DECREE OR CUSTODY ORDER SIGNED
BY A JUDGE, OR OTHER OFFICIAL DOCUMENTATION THAT SHOWS CHANGE IN DEPENDENCY STATUS).
(3) EFFECTIVE DATE OF THE CHANGE IN DEPENDENCY STATUS.
(4) INFORMATION ON WHO HAS RESIDENTIAL CUSTODY OF THE CHILD WITH SPECIAL NEEDS.
INFORMATION PROVIDED IN THE MEMO MAY BE VERIFIED BY THE HSWL FRS.
D. MEMBERS WHO HAVE RESIDENTIAL CUSTODY OF THEIR CHILDREN FOR 30 PERCENT OF THE TIME OR LESS, ANNUALLY, ARE NOT REQUIRED TO ENROLL IN THE SPECIAL NEEDS PROGRAM, OR THEY MAY BE DISENROLLED BY PRODUCING APPROPRIATE DOCUMENTATION (AS DESCRIBED ABOVE IN 5.C.(1),(2),(3),AND (4)).
E. SEPARATION FROM A SPOUSE WITH SPECIAL NEEDS IS NOT GROUNDS FOR DISENROLLMENT FROM THE SPECIAL NEEDS PROGRAM. DISENROLLMENT BECAUSE OF DIVORCE CAN ONLY BE COMPLETED UPON FINAL TERMINATION OF THE MARRIAGE.
F. RETIREMENT, DISCHARGE, OR TRANSFER TO RESERVE STATUS OF AN AD MEMBER WILL PROMPT AUTOMATIC DISENROLLMENT FROM THE SPECIAL NEEDS PROGRAM.

6. FOR ALL NEW ENROLLMENTS AND ENROLLMENT UPDATES PROCESSED AFTER THE EFFECTIVE DAY OF THIS POLICY, DD FORM 2792 (FOR MEDICAL, PSYCHOLOGICAL, AND PHYSICAL CONDITIONS) AND DD FORM 2792-1 (FOR EDUCATIONAL SPECIAL NEEDS) SHALL BE COMPLETED BY THE FAMILY MEMBERS

MEDICAL PROVIDER OR SCHOOL PERSONNEL (RESPECTIVELY) AND SUBMITTED BY THE MEMBER TO THE SERVICING HSWL FRS. NO ADDITIONAL MEDICAL DOCUMENTATION WILL BE REQUIRED. THE FRS WILL FORWARD THE DD FORM 2792 AND 2792-1 TO THE COGNIZANT CG SENIOR MEDICAL EXECUTIVE (SME) FOR VERIFICATION OF ELIGIBILITY FOR ENROLLMENT. AS WARRANTED, THE FRS WILL VERIFY EDUCATIONAL ELIGIBILITY FOR ENROLLMENT BY REVIEWING CHILDS IEP OR IFSP. A DETAILED STANDARD OPERATING PROCEDURE WILL BE PROVIDED TO THE SMES AND FRSS FOR ADDITIONAL GUIDANCE IN THE NEAR FUTURE.

7. COMMANDING OFFICERS AND OFFICERS-IN-CHARGE SHALL ENSURE THAT ALL AD MEMBERS ARE MADE AWARE OF THIS POLICY. THEY SHALL ALSO ENSURE THAT ALL AD MEMBERS WHO HAVE FAMILY MEMBERS WITH SPECIAL NEEDS MEETING THE CRITERIA LISTED ABOVE COMPLY WITH THE MANDATORY ENROLLMENT REQUIREMENT.

8. POC FOR THIS MATTER IS MS. MARTA DENCHFIELD, SPECIAL NEEDS PROGRAM MANAGER. SHE MAY BE REACHED AT 202-475-5156 OR BY EMAIL AT MARTA.E.DENCHFIELD(AT)USCG.MIL.

9. RELEASED BY RADM MARK TEDESCO, DIRECTOR OF HEALTH, SAFETY, AND WORK LIFE.

10. INTERNET RELEASE AUTHORIZED.

INSTRUCTIONS FOR COMPLETING DD FORM 2792, FAMILY MEMBER MEDICAL SUMMARY

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

The addenda to the medical summary are completed only if noted in Item 10 of the Demographics/Certification section (p.3).

The Exceptional Family Member Program (EFMP)/ Special Needs Identification and Clearance (SNIAC) Screening Coordinator and the Parent/Guardian or Person of Majority Age sign Items 6.b and 13.b only after all addenda have been completed and the form reviewed for completeness and accuracy.

AUTHORIZATION FOR DISCLOSURE (Page 1).

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

Each adult family member must sign for the release of his/her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy/HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS/CERTIFICATION (Page 2).

Items 1. Self-explanatory.

Item 2.a. Family Member (FM). Name of family member described in subsequent pages.

Item 2.b. Self-explanatory.

Item 2.c. Applies to Military medical beneficiary only. The Family Member Prefix is assigned when the family member is enrolled in DEERS.

Items 2.d. - i. Self-explanatory.

Items 3.a. - j. All items refer to the sponsor. Self- explanatory.

Item 4.a. Answer Yes if both spouses are on active duty; otherwise answer No.
If Yes, complete Items 4.b. - e. All items refer to the active duty spouse. Self-explanatory.

IItem 5.a. - d. If Yes, enter Social Security Number, name of sponsor and branch of Service. Military only.

Item 6.a. - c. Parent/Guardian or Person of Majority Age. Parent/guardian or person of majority age certifies that the information contained in the DD 2792 is correct. **Individual must ensure that all forms are completed and attached before signing.**

Item 7. Purpose for Completing the Form (X one). Initial Screening Enrollment - Review of medical history for the family member noted for the purpose of determining eligibility for EFMP. Request for government sponsored travel and/or command sponsorship review of projected location(s). Update to previous evaluation for the family member. Qualifies for a change in EFMP status. Used to disenroll an EFMP when he/she no longer has the medical condition that requires enrollment, or when the EFM no longer qualifies as a dependent.

Item 8. Indicate status of medical condition.

Item 9.a. If yes, complete b. - c.

Item 10. Required Addenda. This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum. **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each Military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Items 11.a. - h. Mark (X) all services being provided to the family member.

Item 12.a. Additional Family Member. Answer Yes if there is any member of the family, not including this patient, who has been identified as having special needs.

Item 12.b. Indicate the number of other family members who have been identified as an EFM. **Do not include the individual named in this summary in the count of family members.**

Items 13.a. - e. EFMP/SNIAC/Screening Coordinator or Advisor name, signature, date, facility address, telephone number. Self-explanatory. **Coordinator must ensure that all forms are complete and attached before signing.**

Item 13.f. This area is reserved for Service-specific guidance to validate the form.

MEDICAL SUMMARY beginning on page 4 must be completed by a qualified medical professional.

Sponsor, spouse, or family member of majority age must sign release authorization on page 1 before this summary is completed.

Item 1.a. - c. Pertains to children under 6 years of age. Self-explanatory.

Items 2.a. - d. Temporary Conditions. Self-explanatory.

Item 3.a. Diagnosis. Enter the diagnosis(es), one per line. With the exception of asthma, cancer or mental health, identify all diagnoses that have been active within the last year. For asthma, cancer or mental health, identify all diagnoses active within the last 5 years.

Item 3.b. ICD or DSM. Enter ICD-9-CM or DSM IV designations. **REQUIRED.**

Item 3.c. Medications and Therapies. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 3.d. Enter per diagnosis the number of outpatient visits, ER visits, hospitalizations and ICU admissions for the last 12 months.

Item 4. Prognosis. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 5. Treatment Plan. Self-explanatory. Additional information may be included in item 11 if more space is required.

Item 6. Cancer. Self-explanatory.

Item 7. Minimum Health Care Specialty. Codes in the first column are used by Army coding teams only. In column 1, indicate with an X those specialists essential (required) to meet the needs of the patient. For example, if a developmental pediatrician is a child's primary care provider, but a pediatrician can meet the needs, do not mark developmental pediatrician. In column 2, indicate frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; Bi - Bimonthly; W - Weekly.

Item 8 - Artificial Openings. Self-explanatory.

Item 9 - Environmental/Architectural Considerations. Self-explanatory.

Item 10. Adaptive Equipment/Special Medical Equipment. Self-explanatory.

Item 11. Comments. Enter any additional information that would assist in determining necessary treatment.

Item 12.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and the date the summary was signed. Self-explanatory.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY (p.8)**. To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- d. Self-explanatory.

Items 3.a.- k. Self-explanatory.

Items 4.a. - f. Self-explanatory.

Items 5.a. - d. Self-explanatory.

Items 6.a. - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY
(pp. 9 - 10). **To be completed by a qualified clinical provider.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a. - d. Self-explanatory. Item 2.b. ICD or DSM is **REQUIRED**.

Item 3. Self-explanatory.

Item 4.a. - i. History. Self-explanatory.

Item 5. Prognosis. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 6. Treatment Plan. Self-explanatory. Additional information may be included in Item 9 if more space is required.

Item 7. Expected treatment needs within the next year. Mark only one box considering all diagnoses. Self-explanatory.

Item 8. Required Providers and Frequency of Visits. Mark all providers who are required to implement the treatment plan.

Item 9. Comments. Enter any additional information that would assist in determining necessary treatment.

Items 10.a - f. Provider Information. Official Stamp or printed name and signature of the provider completing this summary, and date the summary was signed. Self-explanatory.

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11)**. To be completed by a qualified medical professional.**

This addendum is completed only if applicable to the patient described. Indicate in block 1 Yes or No. If Yes, proceed with addendum and sign. If No, do not complete addendum . **SIGNATURE of Qualified Medical Provider is REQUIRED.** Each military Service may additionally indicate need to complete addenda in item 10, page 3, when determining the purpose of completing this form and may be completed by a different provider than pages 4 - 7, if necessary.

Item 1. Self-explanatory.

Items 2.a.- b. Diagnosis(es). Self-explanatory.

Items 3. Self-explanatory.

Item 4. Coexisting Diagnoses. Indicate coexisting diagnosis.

Item 5. Current Medications. Self-explanatory.

Item 6. Current Interventions/Therapies. Indicate current interventions/therapies, if known.

Item 7. Communication. Self-explanatory.

Item 8. Other Interventions/Therapies Used by the Family. Specify any alternate or complementary therapies used.

Item 9. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 14 if more space is required.

Item 10. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Item 11. Education. Self-explanatory.

Item 12. Required Medical Services. Self-explanatory.

Item 13. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 14. General Comments. Self-explanatory.

Item 15. Provider Information. Official Stamp or printed name and signature of the provider completing this summary and date the summary was signed. Self-explanatory.

FAMILY MEMBER MEDICAL SUMMARY

(To be completed by service member, adult family member, or civilian employee.)
(Read Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires Mar 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at http://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment.
Mandatory for military personnel: failiure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are noted in the official military personnel files which are retrieved by name and Social Security Number.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing this authorization, you confirm you understand your sponsor will have access to the health information contained herein and in addenda. The sponsor may be held accountable for the accuracy and completeness of the DD 2792 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTF/DTF/Civilian Provider) (Name of Provider)
to release my patient information to the Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs, if EFMP enrollment criteria are met.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services.
Start Date: The authorization start date is the date that you sign this form authorizing release of information.
Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.

b. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above for the stated purposes.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status.

e. Failure to release this information or any subsequent revocation may result in ineligibility for community based services, and/or accompanied family travel at government expense.

f. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

NAME OF PATIENT	SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT *(If applicable)*	DATE *(YYYYMMDD)*

DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM *(X one)*

- ☐ EFMP REGISTRATION/ENROLLMENT UPDATE
- ☐ REQUEST CHANGE IN EFMP STATUS
- ☐ SUMMARIZE MEDICAL INFORMATION FOR OFFICIAL USES
- ☐ NO LONGER HAVE PREVIOUSLY IDENTIFIED CONDITION
- ☐ FAMILY MEMBER DECEASED*
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP
- ☐ NO LONGER QUALIFIES AS A DEPENDENT*
- ☐ DIVORCE/CHANGE IN CUSTODY*
- ☐ OTHER *(Explain)*:

*(*Maintain documentation to verify change in status - do not update medical information.)*

2.a. FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)*	b. SPONSOR NAME *(Last, First, Middle Initial)*	c. FAMILY MEMBER PREFIX (FMP)	d. SPONSOR SSN

e. FAMILY MEMBER GENDER *(X)*	f. FAMILY MEMBER DATE OF BIRTH *(YYYYMMDD)*	g. CURRENT FAMILY MEMBER MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
☐ MALE ☐ FEMALE		
h. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	i. FAMILY HOME E-MAIL ADDRESS	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT

d. BRANCH OF SERVICE *(Military only)*	e. STATUS *(X one)*
☐ ARMY ☐ AIR FORCE	☐ REGULAR ACTIVE SERVICE MEMBER ☐ RESERVIST ☐ CIVILIAN
☐ NAVY ☐ MARINE CORPS	☐ ACTIVE GUARD RESERVE PROGRAM (AGR) ☐ NATIONAL GUARD

f. SPONSOR'S CURRENT UNIT MAILING ADDRESS

g. SPONSOR'S OFFICIAL E-MAIL ADDRESS	h. DUTY TELEPHONE NUMBER *(Include Area Code/CountryCode)*	i. MOBILE NUMBER *(Include Area Code/Country Code)*

j. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one. If No, explain.)*

- ☐ YES
- ☐ NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, complete 4.b. - e. below)*

	b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN
☐ YES				
☐ NO				

5.a. IS FAMILY MEMBER ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME? *(Military only) (X one)*

	b. IF YES, UNDER WHAT SSN	c. NAME OF SPONSOR *(Last, First, Middle Initial)*	d. BRANCH OF SERVICE
☐ YES			
☐ NO			

6. CERTIFICATION. DO NOT CERTIFY BEFORE COMPLETING ENTIRE FORM AND ADDENDA.

By signing below, we certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked below) is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS *(X one)*

- ☐ FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)
- ☐ UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER
- ☐ OTHER *(e.g., Extended Care Health Option Eligibility)*:

- ☐ QUALIFIES FOR CHANGE IN EFMP STATUS:
  - ☐ FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION
  - ☐ FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*
  - ☐ FAMILY MEMBER DECEASED*
  - ☐ DIVORCE/CHANGE IN CUSTODY*

*(*Maintain documentation to verify change in status - do not update medical information.)*

8. SUMMARY *(X one)*

☐ ONGOING MEDICAL CONDITIONS ☐ TEMPORARY MEDICAL CONDITIONS ☐ BOTH

9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? *(X one)*

☐ YES ☐ NO *(If Yes, complete 9.b. and c.)*

b. LOCATION OF CASE MANAGER *(X)* ☐ MTF ☐ TRICARE ☐ CIVILIAN

c. CASE MANAGER CONTACT INFORMATION

(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE NUMBER *(Include Area Code/Country Code)*	(3) ADDRESS *(Include ZIP Code or APO/FPO)*

10. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 8) and item 1 on Addendum 2 (page 9) and item 1 on Addendum 3 (page 11) AND X box below if:

- ☐ ASTHMA ADDENDUM 1 IS REQUIRED AND ☐ ATTACHED
- ☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND ☐ ATTACHED
- ☐ AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND ☐ ATTACHED

11. SPECIAL ASSIGNMENT CONSIDERATIONS *(X all that apply)*

- ☐ a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION *(If marked, DD Form 2792-1 must be completed)*
- ☐ b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS
- ☐ c. RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ d. RECEIVING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ e. RECEIVING STATE MEDICAID OR MEDICARE WAIVER SERVICES
- ☐ f. RECEIVING VOCATIONAL REHABILITATION SERVICES
- ☐ g. RECEIVING SPECIAL CHILD CARE ACCOMMODATIONS
- ☐ h. OTHER *(Specify)*

12.a. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY *(Not including this family member)*?

☐ YES ☐ NO b. IF YES, HOW MANY? _____

13. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. TITLE	c. SIGNATURE	d. DATE *(YYYYMMDD)*

e. FACILITY ADDRESS *(Include ZIP Code or APO/FPO)*	f. TELEPHONE NUMBER *(Include area code/Country Code)*	g. OFFICIAL STAMP

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS *(Authorization by patient or parent/guardian included on Page 1 of this form)*

1. FOR CHILDREN UNDER AGE 6 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? *(X one)*

☐ YES ☐ NO

b. DATE OF LAST WELL-CHILD EXAMINATION *(YYYYMMDD)*

c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? *(X one. If No, please explain.)*

☐ YES ☐ NO

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME *(Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel limitations.)*

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV Use item 11 (Comments) if more space is needed.

If Asthma or RAD is noted, also complete Asthma Addendum 1.
If Mental Health is noted, to include Attention Deficit Disorders, also complete Mental Health Addendum 2.
If Autism Spectrum Disorder(ASD)/Developmental Delay (DD) is noted, also complete Addendum 3.

a. ACTIVE DIAGNOSIS REQUIRING CARE WITHIN LAST YEAR *(If Asthma, Cancer or Mental Health within last 5 years)*	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES *(Also annotate rare or special consideration medications used within specified time period)*	d. COMPLETE FOR THE LAST 12 MONTHS:	
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS
				(1) NUMBER OF OUTPATIENT VISITS
				(2) NUMBER OF ER VISITS
				(3) NUMBER OF HOSPITALIZATIONS
				(4) NUMBER OF ICU ADMISSIONS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

4. PROGNOSIS FOR EACH ACTIVE DIAGNOSIS IDENTIFIED IN PART A, ITEM 3 *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

5. TREATMENT PLAN FOR EACH ACTIVE DIAGNOSIS *(Medical, mental health, surgical procedures or therapies planned over the next three years)*

6. CANCER, ADDITIONAL INFORMATION *(If not addressed in Items 3, 4, and 5) (Indicate date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment completed.)*

IF TREATMENT COMPLETED, DATE *(YYYYMMDD)* _____

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

PART B - REQUIRED CARE

7. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY *(Twice a year)* Q - QUARTERLY M - MONTHLY BI - BI-MONTHLY W - WEEKLY

	(1) CARE PROVIDER *(X as appropriate)*		(2) FREQUENCY *(See above)*
C01		a. ALLERGIST/IMMUNOLOGIST	
C52		b. AUDIOLOGIST	
C42		c. CARDIAC/THORACIC SURGEON	
C02		d. CARDIOLOGIST - ADULT	
C03		e. CARDIOLOGIST - PEDIATRIC	
C70		f. CLEFT PALATE TEAM - PEDIATRIC	
C05		g. DERMATOLOGIST	
C06		h. DEVELOPMENTAL PEDIATRICIAN	
C53		i. DIALYSIS TEAM	
C07		j. DIETARY/NUTRITION SPECIALIST	
C08		k. ENDOCRINOLOGIST - ADULT	
C09		l. ENDOCRINOLOGIST - PEDIATRIC	
C10		m. FAMILY PRACTITIONER	
C11		n. GASTROENTEROLOGIST - ADULT	
C12		o. GASTROENTEROLOGIST - PEDIATRIC	
C43		p. GENERAL SURGEON	
C14		q. GENETICS	
C15		r. GYNECOLOGIST	
C17		s. HEMATOLOGIST/ONCOLOGIST - ADULT	
C18		t. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC	
C75		u. INFECTIOUS DISEASE	
C20		v. INTERNIST	
C21		w. NEPHROLOGIST - ADULT	
C22		x. NEPHROLOGIST - PEDIATRIC	
C23		y. NEUROLOGIST - ADULT	
C24		z. NEUROLOGIST - PEDIATRIC	
C44		aa. NEUROSURGEON	
C54		bb. OCCUPATIONAL THERAPIST - ADULT	
C55		cc. OCCUPATIONAL THERAPIST - PEDIATRIC	
C26		dd. OPHTHALMOLOGIST - ADULT	
C27		ee. OPHTHALMOLOGIST - PEDIATRIC	
C57		ff. ORAL SURGEON	

	(1) CARE PROVIDER *(X as appropriate)*		(2) FREQUENCY *(See above)*
C56		gg. OTORHINOLARYNGOLOGIST	
C47		hh. ORTHOPEDIC SURGEON - ADULT	
C48		ii. ORTHOPEDIC SURGEON - PEDIATRIC	
C77		jj. PAIN CLINIC	
C72		kk. PEDIATRIC NURSE PRACTITIONER	
C30		ll. PEDIATRICIAN	
C49		mm. PEDIATRIC SURGEON	
C32		nn. PHYSIATRIST *(Physical Rehabilitation)*	
C58		oo. PHYSICAL THERAPIST	
C50		pp. PLASTIC SURGEON - ADULT	
C71		qq. PLASTIC SURGEON - PEDIATRIC	
C35		rr. PSYCHIATRIST - ADULT	
C36		ss. PSYCHIATRIST - PEDIATRIC	
C72		tt. PSYCHIATRIST NURSE PRACTITIONER	
C37		uu. PSYCHOLOGIST - ADULT	
C38		vv. PSYCHOLOGIST - PEDIATRIC	
C33		ww. PULMONOLOGIST - ADULT	
C76		xx. PULMONOLOGIST - PEDIATRIC	
C60		yy. RESPIRATORY THERAPIST	
C39		zz. RHEUMATOLOGIST - ADULT	
C40		aaa. RHEUMATOLOGIST - PEDIATRIC	
C61		bbb. SOCIAL WORKER	
C62		ccc. SPEECH AND LANGUAGE PATHOLOGIST	
C41		ddd. TRANSPLANT TEAM	
C51		eee. UROLOGIST - ADULT	
C78		fff. UROLOGIST - PEDIATRIC	
C99		ggg. OTHER *(Describe)*	

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Professional

8. ARTIFICIAL OPENINGS/PROSTHETICS *(X all that apply)*

☐ YES IF YES:
☐ NO

☐ F01 - GASTROSTOMY
☐ F02 - TRACHEOSTOMY
☐ F03 - CSF SHUNT
☐ F04 - CYSTOSTOMY
☐ F05 - COLOSTOMY
☐ F06 - ILEOSTOMY
☐ F07 - OTHER UNSPECIFIED PROSTHETICS *(Specify)*
☐ F99 - OTHER UNSPECIFIED OPENING *(Specify)*

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

☐ R01 - LIMITED STEPS *(If Yes, please explain)*
☐ R02 - COMPLETE WHEELCHAIR ACCESSIBILITY
☐ R04 - SINGLE STORY/LEVEL HOUSE
☐ R05 - CARPET PROHIBITED
☐ R99 - OTHER *(Specify)*
☐ R03 - AIR CONDITIONING
☐ R03a - TEMPERATURE CONTROL
☐ R03b - HEPA FILTER
☐ R03c - POLLEN CONTROL
☐ R03d - AIR FILTERING

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(If marked, describe type of equipment in item 11 (Comments) below.)*

☐ L03 - APNEA HOME MONITOR
☐ L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
☐ L20 - HOME DIALYSIS MACHINE
☐ L13 - HOME NEBULIZER
☐ L04 - HEARING AIDS: MAKE: MODEL:
☐ L22 - INSULIN PUMP: MAKE: MODEL:
☐ L23 - PACEMAKER: MAKE: MODEL:
☐ L99 - OTHER *(Specify)*
☐ L07 - SPLINTS, BRACES, ORTHOTICS
☐ L08 - WHEELCHAIR
☐ L12 - HOME OXYGEN THERAPY
☐ L14 - HOME VENTILATOR

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

PART C - PROVIDER INFORMATION

12.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY: To be completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR TREATED FOR ASTHMA WITHIN THE PAST 5 YEARS.

☐ NO ☐ YES IF YES, CONTINUE COMPLETION OF ASTHMA ADDENDUM ITEMS 2 - 6.

2. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. FREQUENCY	d. APPROXIMATE DATE MEDICATION LAST USED

3. HISTORY ASSOCIATED WITH ASTHMA ATTACKS *(X as applicable)*

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environment, exercise)*?
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES', INDICATE THE NUMBER OF VISITS IN THE PAST YEAR:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* DURING THE PAST YEAR? IF "YES', INDICATE THE DATE(S) OF HOSPITALIZATION *(YYYYMMDD)*:
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES', HOW MANY? INDICATE DATE OF LAST ADMISSION *(YYYYMMDD)*:
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to physicians)* DURING THE PAST YEAR?

k. HOW OFTEN DOES THE FAMILLY MEMBER USE HIS/HER RESCUE INHALER OR NEBULIZER MEDICATION *(such as Albuterol or Levalbuterol)* FOR INCREASED OR ACUTE SYMPTOMS?

4. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZING WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

5. SEVERITY LEVEL. What is the family member's severity level based on the current treatment plan? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

☐	a. INTERMITTENT ASTHMA. Intermittent symptoms ≤ 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms < 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 ≥ 80% predicted; variability <20%.
☐	b. MILD PERSISTENT ASTHMA. Symptoms ≥ 2 times a week but < 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms > 2 times a month. PEF or FEV1 ≥ 80% predicted; variability 20 - 30%.
☐	c. MODERATE PERSISTENT. Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 ≥ 60% and 80% predicted; variability > 30%.
☐	d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 ≤ 60% predicted; variability > 30%.

6.a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(include Area Code/Country Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be Completed by a Qualified Clinical Provider

1. PATIENT HAS CURRENT OR PAST *(within the last 5 years)* HISTORY OF MENTAL HEALTH DIAGNOSIS *(To include attention deficit disorders)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF MENTAL HEALTH ADDENDUM.

2. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. AGE AT DIAGNOSIS	d. COMPLETE FOR THE LAST 5 YEARS
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:
			☐ (1) NUMBER OF OUTPATIENT VISITS ☐ (2) NUMBER OF HOSPITALIZATIONS ☐ (3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS DATE OF LAST ADMISSION:

3. MEDICATION HISTORY RELATED TO THE DIAGNOSIS LISTED ABOVE; THERAPIES RECEIVED OR RECOMMENDED
(Including frequency of medication and therapy, and their effectiveness)

4. HISTORY

YES	NO	WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD:
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
		b. HISTORY OF SUBSTANCE ABUSE?
		c. HISTORY OF ADDICTIVE BEHAVIORS?
		d. HISTORY OF EATING DISORDERS?
		e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
		f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? *(If Yes, specify)*
		g. HISTORY OF PSYCHOTIC EPISODES?
		h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If Yes, and services are delivered by Family Advocacy, note case determination.)*

i. COMMENTS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 2 - MENTAL HEALTH SUMMARY *(Continued)*: To be Completed by a Qualified Clinical Provider

5. PROGNOSIS *(Include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)*

6. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies related to the patient's mental health condition planned over the next three years)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g.,stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

8. PROVIDERS REQUIRED TO IMPLEMENT TREATMENT PLAN AND FREQUENCY OF VISITS

☐ PSYCHIATRIST	☐ PSYCHOLOGIST	☐ SOCIAL WORKER	☐ OTHER *(Specify)*
☐ WEEKLY	☐ WEEKLY	☐ WEEKLY	☐ WEEKLY
☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY	☐ BI-MONTHLY
☐ MONTHLY	☐ MONTHLY	☐ MONTHLY	☐ MONTHLY
☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY	☐ QUARTERLY
☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY	☐ ANNUALLY

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

10. PROVIDER INFORMATION *(Authorization by patient included on Page 1 of this form.)*

a. PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*			e. MAILING ADDRESS *(Include ZIP Code)*
(1) COMMERCIAL	(2) DSN *(Military only)*	(3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS			

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS

To be Completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR RECEIVED TREATMENT(S) FOR AUTISM SPECTRUM DISORDERS AND/OR SIGNIFICANT DEVELOPMENTAL DELAYS *(X one)*

☐ NO ☐ YES IF YES, CONTINUE WITH COMPLETION OF AUTISM AND SIGNIFICANT DEVELOPMENTAL DELAYS ADDENDUM 3, ITEMS 2 - 15.

2.a. DIAGNOSIS(ES) *(X and complete as applicable)*

☐ AUTISTIC DISORDER
☐ ASPERGER'S SYNDROME
☐ PERVASIVE DEVELOPMENTAL DISORDER/NOS
☐ OTHER *(Specify)*

b. AGE WHEN DIAGNOSED

3. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

☐ CHILD PSYCHOLOGIST ☐ DEVELOPMENTAL PEDIATRICIAN ☐ OTHER PHYSICIAN ☐ OTHER *(Specify)*
☐ CHILD PSYCHIATRIST ☐ MEDICAL MULTIDISCIPLINARY TEAM ☐ SCHOOL-BASED TEAM

4. COEXISTING DIAGNOSES *(X all that apply)*

☐ CHROMOSOMAL ABNORMALITIES ☐ INTERMITTENT EXPLOSIVE DISORDER ☐ MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS
☐ OBSESSIVE COMPULSIVE DISORDER ☐ CIRCADIAN-RHYTHM SLEEP DISORDER ☐ SEIZURE DISORDER
☐ ATTENTION DEFICIT/HYPERACTIVITY DISORDER ☐ GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS ☐ OTHER *(Specify)*

5. CURRENT MEDICATIONS *(Used to treat diagnoses on this page)*

6. CURRENT INTERVENTION THERAPIES

(1) TYPE	(2) SCHOOL HOURS/WEEK *(If known)*	(3) TRICARE HOURS/WEEK *(If known)*	(4) OTHER SOURCE HOURS/WEEK *(If known)*	(5) OTHER *(Identify)*
a. SPEECH THERAPY				
b. OCCUPATIONAL THERAPY				
c. PHYSICAL THERAPY				
d. PSYCHOLOGICAL/COUNSELING				
e. INTENSIVE BEHAVIORAL INTERVENTION *(Includes ABA)*				
f. OTHER *(Specify)*				

7. COMMUNICATION *(X)*

☐ VERBAL ☐ NON-VERBAL *(Uses:)*
☐ SIGNING
☐ PICTURE EXCHANGE COMMUNICATION SYSTEM (PECS)
☐ COMMUNICATION DEVICE
☐ COMBINATION

8. OTHER INTERVENTIONS/THERAPIES USED BY THE FAMILY *(Specify alternate or complementary therapies)*

9. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR

☐ YES ☐ NO *(If Yes, provide details in Item 14 below)*

10. COGNITIVE ABILITY *(X)*

☐ <50 ☐ UNKNOWN
☐ 50 - 70 ☐ INDETERMINATE
☐ >70

11. EDUCATION *(X)*

☐ RECEIVES EARLY INTERVENTION ☐ ATTENDS PUBLIC SCHOOL
☐ RECEIVES SPECIAL EDUCATION ☐ ATTENDS PRIVATE SCHOOL
☐ ATTENDS SPECIAL PRIVATE SCHOOL ☐ IS HOME SCHOOLED

12. REQUIRED MEDICAL SERVICES *(X)*

☐ CHILD PSYCHOLOGY ☐ CHILD NEUROLOGY
☐ CHILD PSYCHIATRY ☐ DEVELOPMENTAL PEDIATRICS
☐ OTHER *(Specify)*

13. RESPITE CARE RECEIVED

a. HOURS PER MONTH

b. SOURCE

14. GENERAL COMMENTS *(Include Functional Levels)*

15. PROVIDER INFORMATION

a. PRINTED NAME OR STAMP

b. SIGNATURE

c. DATE *(YYYYMMDD)*

d. TELEPHONE NUMBERS *(Include Area Code)*

(1) COMMERCIAL (2) DSN *(Military only)* (3) FAX NUMBER

f. OFFICIAL E-MAIL ADDRESS

e. MAILING ADDRESS *(Include ZIP Code)*

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special education needs of family members. This information will enable: (1) Military assignment personnel to match the special education needs of family members against the availability of educational services, and (2) Civilian personnel officers to advise civilian employees about the availability of education services to meet the special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at http://privacy.defense.gov/notices.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; however, the information must be provided if you intend to enroll your child with special education needs in a school funded by the Department of Defense.
Mandatory for military personnel. Failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the DoD Education Activity and Service personnel offices to work together to ensure any special education needs of your dependent can be met at your next duty assignment. Dependent special education needs are noted in the official military personnel files which are retrieved by name and Social Security Number.

INSTRUCTIONS

The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.

DEMOGRAPHICS.

Items 1 - 7. Completed by sponsor or spouse.

Item 1. Request (X one):
- EFMP Registration/Enrollment Update - first exceptional family member (EFM) application for the family member or to update a previous EFM evaluation for the family member.
- Government sponsored travel and/or Command Sponsorship.
- Change in EFMP Status.

Items 2.a. - g. Child/Student Information. Self-explanatory.

Items 3.a. - j. Sponsor Information. Self-explanatory.

Item 3.k. Is family member enrolled in DEERS? Military only. Self-explanatory.

Items 4.a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3 only. Self-explanatory.

Item 6. Completed for children ages 3 to 21 only. Self-explanatory.

Items 7.a. - c. Signature of sponsor or spouse who completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP/Special Needs Office resonsible for screening or enrollment in the MTF.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.**

Items 1.a. - d. Sponsor Information. Completed by sponsor or spouse. Self-explanatory.

Items 2.a. - d. Child/Student Information. Completed by sponsor or spouse. Self-explanatory.

Items 3.a. - e. EIP Information. Completed by EIP or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 4.a. - g. School Information. Completed by school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Item 5. Completed by school personnel. Mark (X) eligibility category. Mark only one. (Codes are for Army coding only.)

Item 6. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Item 7. Completed by EIP and school personnel. Self-explanatory.

Item 8. Completed by EIP provider/school official information completing form. Self-explanatory.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

(Page 1, Items 1 - 7 to be completed by sponsor, parent or legal guardian.)
(Read Privacy Act Statement and Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires
Mar 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

DEMOGRAPHICS

1. REQUEST *(X one)*

- ☐ EFMP Registration/Enrollment Update
- ☐ Government Sponsored Travel and/or Command Sponsorship
- ☐ Change in EFMP Status:
  - ☐ No longer requires IEP/IFSP services
  - ☐ No longer qualifies as a dependent*
  - ☐ Divorce/change in custody*
- ☐ Other *(Explain)*:

*(*Provide documentation for change in status)*

2.a. CHILD/STUDENT NAME *(Last, First, Middle Initial)*	b. SPONSOR NAME *(Last, First, Middle Initial)*	c. CHILD/STUDENT CURRENT MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO/FPO)*
d. CHILD/STUDENT DATE OF BIRTH *(YYYYMMDD)*	e. CHILD/STUDENT GENDER *(X one)* ☐ MALE ☐ FEMALE	
f. FAMILY HOME E-MAIL ADDRESS	g. HOME TELEPHONE NUMBER *(Include Area Code/Country Code)*	

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC *(Military only)*	c. INSTALLATION OF CURRENT ASSIGNMENT
d. SPONSOR'S OFFICIAL E-MAIL ADDRESS	e. DUTY TELEPHONE NUMBER *(Include Area Code/Country Code)*	f. MOBILE NUMBER *(Include Area Code/Country Code)*

g. SPONSOR'S CURRENT UNIT MAILING ADDRESS	h. STATUS *(X one)*	d. BRANCH OF SERVICE *(Military only)*
	☐ Regular Active Service Member ☐ Active Guard/Reserve Program (AGR) ☐ Reservist ☐ National Guard ☐ Civilian	☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps

j. DOES CHILD RESIDE WITH SPONSOR? *(X one. If No, explain.)*

☐ YES ☐ NO

k. IS THE CHILD/STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? *(X one. If Yes, provide name of sponsor:)*

☐ YES ☐ NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? *(Military only) (X one. If Yes, answer b. - d. below)*

☐ YES ☐ NO	b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)*	c. BRANCH OF SERVICE	d. RANK/RATE

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY:

☐ YES ☐ NO Is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)?
(X one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 2.)

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION:

☐ YES ☐ NO a. Is your child being home-schooled? *(X one. If No, sign Item 7 and take Page 2 to your child's school. If Yes, complete the following and sign Item 7.)*

b. When did you start home-schooling? *(YYYYMMDD)* _____

c. List any special education-related services received in the last 3 years:

_____

d. Name/title home school program, if known: _____

7.a. SIGNATURE	b. PRINTED NAME *(Last, First, Middle Initial)*	c. DATE *(YYYYMMDD)*

8. ADMINISTRATIVE REVIEW *(Completed after review of entire form by local military MTF or office receiving form)*

a. SPONSOR SSN	b. SPOUSE SSN *(If dual military)*	c. SSN USED IN DEERS *(If different from sponsor's)*	STAMP

d. FAMILY MEMBER PREFIX	e. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM	f. DATE *(YYYYMMDD)*

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:
It is important to the military and to the family that the family be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) or Section 504 Plan to this page.)*

1. RELEASE OF INFORMATION *(To be completed by sponsor, spouse, or student who has reached the age of majority)*
I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child/student's needs for educational services for the purpose of assignment/coordination, EFMP registration or eligibility for other educationally related benefits.

a. SIGNATURE OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY	b. PRINTED NAME	c. RELATIONSHIP TO CHILD/ STUDENT	d. DATE *(YYYYMMDD)*

2. CHILD/STUDENT INFORMATION *(To be completed by sponsor or spouse)*

a. NAME OF CHILD/STUDENT *(Last, First, Middle Initial)*	b. CURRENT GRADE LEVEL *(If school age)*	c. DATE OF BIRTH *(YYYYMMDD)*	d. GENDER *(X one)*
			☐ FEMALE ☐ MALE

3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE *(To be completed by EI representative)*

YES	NO	
☐	☐	a. Is the child currently being evaluated for early intervention services? *(If Yes, go directly to Item 8.)*
☐	☐	b. Does this child receive early intervention services under a current Individualized Family Services Plan (IFSP)?

(If Yes, please attach current IFSP.) Date of next annual review *(YYYYMMDD)*: _____

c. Basis for eligibility: ☐ Developmental delay ☐ High probability for developmental delay

d. Identified disability for diagnosis: _____

4. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 *(To be completed by school representative)*

YES	NO	
☐	☐	a. Is the student receiving services under a 504 plan? *(If Yes, please attach a copy of the current 504 plan.)*
☐	☐	b. Has this child ever been evaluated for, or been offered, special education services by your school? *(If No, skip to Item 8.)*
☐	☐	c. Is this student currently being evaluated for special education services? *(If Yes, skip to Item 8.)*
☐	☐	d. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)*
☐	☐	e. Does this child/student receive special education services under a current Individualized Education Program (IEP)? *(If Yes, please attach a copy of the current IEP, and complete Items 5 and following.)* Date of next annual review *(YYYYMMDD)*: _____
☐	☐	f. Were IEP services terminated by the IEP team within the last 2 years? *(If Yes, skip to Item 8.)* Date of IEP termination *(YYYYMMDD)*: _____
☐	☐	g. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 5 and following.)*

5. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE *(X only one)*

	N07	Autism Spectrum Disorder:		N09	Communication Impaired:		N12	Specific Learning Disability
		Autism			Articulation		N10	Emotionally Impaired
		PDD-NOS			Dysfluency		N16	Behavioral/Conduct Disorder
		Asperger's Syndrome			Voice		N04	Mental Retardation:
	N01	Deaf			Language/Phonology			Mild/Moderate
	N02	Blind		N05	Traumatic Brain Injury			Moderate/Severe
	N13	Deaf/Blind		N03	Hearing Impaired			Severe/Profound
	N11	Visually Impaired		N06	Orthopedically Impaired		N08	Other Health Impaired *(Specify)*

6. RELATED SERVICES ON IEP *(X boxes next to related services and indicate total number of minutes or hours that services are provided.)*

SERVICE: M = Minutes, H = Hours per W = Week, M = Month Example: 20 | M | per | W

	R01	Counseling			per		
	R02	Occupational Therapy			per		
	R03	Physical Therapy			per		
	R04	Speech Therapy			per		
	R05	Intensive Behavioral Intervention *(Such as ABA)*			per		

☐ R06 Special Transportation *(Describe)*:

☐ R07 Other *(Describe)*:

7. BEHAVIOR/COMMUNICATION *(X all that apply and explain in comments section.)*

YES	NO	
☐	☐	a. Child exhibits high risk or dangerous behavior.
☐	☐	b. Child is verbal *(If No, answer c.-f. The student uses:)*
☐	☐	c. Signing *(Specify language or system)*
☐	☐	d. Picture Exchange Communication System (PECS)
☐	☐	e. Communication Device *(Specify)*
☐	☐	f. Other *(Specify)*

g. COMMENTS

8. PROVIDER/SCHOOL INFORMATION

a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL	b. SCHOOL DISTRICT
c. ADDRESS *(Street, City, State,ZIP Code, APO/FPO)*	d. TELEPHONE NUMBER *(Include Area Code/ Country Code)*

e. FAX NUMBER *(Include Area Code/ Country Code)*	f. E-MAIL ADDRESS	g. NAME OF INDIVIDUAL COMPLETING THIS SECTION

h. SIGNATURE	i. TITLE	j. DATE SIGNED *(YYYYMMDD)*