EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

NAME O	F MEDICAL	TREATMENT	FACILITY
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For use of this	form, see AR 608-7	'5; the proponent age	ncy is OACSIM								
		DATA REQUIRED E	BY THE PRIVACY	ACT OF 1	974						
AUTHORITY:	PL 94-142 (Education for all Handicapped Children Act of 1975), PL 95-561 (Defense Dependents' Education Act of 1978); DODI 1342.12 (Education of Handicapped Children in DODDS), 17 December 1981; DODI 1010.13 (Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States), 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et se										
PRINCIPAL PURPOSE:	To obtain information	ion needed to evalua	te and document th	f family members.							
	This will permit consideration of special education and medical needs of family members in the personnel										
ROUTINE USES:	Information will be used by personnel of the Military Departments to evaluate and document special education and medical needs of family members for consideration in personnel assignments.										
DISCLOSURE:	The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.										
SERVICE MEMBER'S NA				DATE (YYYYMMDD)							
BRANCH		UNIT			DUTY PHONE						
PROJECTED PCS ASSIG	NMENT	DSN			HOME P	HOME PHONE					
HON		HOME ADDRESS			DUTY ADDRESS						
PROJECTED PCS DATE											
LIST ALL	RS	FAMILY MEMBER PREFIX	SEX		TE OF BIRTH YYYYMMDD)	CHECK IF ENROLLED IN EFMP					
	PLEASE	ANSWER ALL QUE	STIONS - FOR FA	MILY ME	MBERS ON	NLY					
Do any family members you have provided us to so						er than the records	YES NO				
FAMILY M	CONDITI	ONS/SERVICES		NAMI	E/ADDRESS OF PRO	OVIDER					
2. In the past five (5) years, have any members of your family, excluding service member, been hospitalized, excluding hospitalization for normal uncomplicated childbirth? If yes, please explain.											
NAN	лF	1		F	REASON						
				<u> </u>							
Are any members of yoeducational services from	our family, excluding any providers other	I g service member, cui than a general pract	rrently receiving me itioner or family pra	edical <i>(ir</i> actice phy	ncludes mer rsician?	ntal health) or	YES NO				

	e any family members, excluding service memb ar basis?	er, ta	aking	g an	ту р	oreso	cribed	medication other than birth control pills on a		YES	S	NO)
NAME								PRESCRIBED MEDICATION					_
													_
	the past five (5) years, have any members of yo following? (You will have an opportunity to disc							ce member, been treated for, or had any problem ith a screener.)	ıs re	lated	l to	any	
a.	Problems with sight (other than corrected by glasses)		YES	ES	N	NO	g.	Asthma, allergies or other respiratory problems		YES	;	NO	<u></u>
b.	Problems with hearing						h.	Cerebral Palsy	\perp				
c.	Heart condition	_		Ц	_		i.	Delayed Speech	4		4	\perp	_
	d. Seizure disorder e. Loss of mobility (requiring use of a wheelchair/ walker or aid in mobility)			Ц			j.	Sickle Cell Trait/Disease	+	_	\dashv	+	_
е.]			k.	Cancer High blood pressure	+		\forall		+
f.	Diabetes						m.	Other, if yes, explain					
MEN.	TAL HEALTH:												
	the past five (5) years, have any members of you following? (You will have an opportunity to disc							ce member, been treated for, or had any problem ith a screener.)	ıs re	lated	d to	any	,
a.	Referral to, diagnosed by, or therapy with a	T	YES	3	N	10		Alcohol and drug use or abuse			;	NO)
	Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem			ı T	Г	\neg	d.				Ц		\int
	·	4		1	L	_	e.	Emotional problems	4		Ц	_	_
b.	Depression	4		Ц			f.	Behavioral problems/acting out behavior	+		4		
c.	Suicidal thoughts/ideas, gestures, attempts]			g.	Received therapy (marital, family, individual or group counseling)					
	ave any members of your family, excluding servi								T	YES	;	NC	5
	dential Treatment Center, Group Homes, Day Troplease explain:	eatm	ent	Cer	nter	rs, D	rug aı	nd Alcohol Treatment Rehabilitation Center. If					
					E	DUC	ATIOI	N					_
8. Do	any of your children now have, or have they eve	er ha	d, aı	ny c									_
a.			YES	3	NO	Ю		Ĭ		YES	;	NO	5
	Slow development (infants and preschoolers)			d. Counseling services for school-related pro					s				1
b. c.				\dashv			 	 			_	_	_
С.	for special education			J	L		e.	Mental retardation					
9. Are any of your children receiving Special Education help in school (not in regular class placement and on an Individual Education Plan (IEP))? If yes, who?)				
by Ar	my officials. Knowingly providing false informati	ion ir	n this	s re	gar	rd m	ay be	ovide accurate information as required when required the basis for disciplinary or administrative action cation for family travel or command sponsorship.					
family		(A	false	e off	ficia	al st	ateme	ide false information, or who knowingly fail or refunct is a violation of Article 107, Uniform Code of Ireprimand.					
All the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide any information about changes in medical or educational status for all members of my family, after the date indicated below, and prior to PCS move.													
PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM			SIGNATURE OF MILITARY SPONSOR OR SPOUSE DATE (Y'COMPLETING THIS FORM						YYY	YYYMMDD)			
5. 5.	SSE SSMI EETING TIMOTONW		COM LETING THOTONW										
PRIN	TED NAME OF PHYSICIAN OR MEDICAL							HYSICIAN OR MEDICAL DATE (Y	ΥΥ	/MMI	DD))	_
PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN				PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN							,		

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