EFMP Quick Reference Guide

Navigate and understand:

- EFMP Enrollment
- EFMP Family Support
- Family Travel Screening

2014

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This guide provides instructions for individuals serving the Exceptional Family Member Program (EFMP) to navigate the enrollment and Family Travel Screening processes for the Army, Marine Corps, Navy, and Air Force. An introduction to EFMP Family Support and Family Support contact information are included for your reference. For your convenience, search tools for contact information and relevant forms can also be found in this guide.

A. INTRODUCTION TO THE EFMP ENROLLMENT PROCESS

Enrollment in the EFMP is mandatory for Active Duty Service members. When a family member is identified with special medical and/or educational needs, the special needs are documented through enrollment in the EFMP. Enrollment ensures that the family member's documented medical and educational needs are considered during the assignment process.

This section provides instructions to navigate the enrollment process for the Army, Marine Corps, Navy, and Air Force. Copies of enrollment forms for each Service can be found in the Appendix.

NOTE: Members of the Guard or Reserves may enroll in the EFMP according to Service-specific guidance.

ARMY EFMP ENROLLMENT

1. The completed DD 2792 and/or DD 2792-1 forms and any applicable attachments are submitted to an Army Medical Treatment Facility (MTF) to the attention of the EFMP Case Coordinator, using the contact information listed below.
2. The EFMP Case Coordinator conducts an administrative review of the forms.
3. Following the administrative review, the EFMP Case Coordinator forwards the forms to the appropriate Regional Medical Command (RMC).
4. The RMC reviews the forms to determine medical and/or educational eligibility.
5. If eligible, the RMC enters the data into an automated EFMP database on the Army Personnel Network.
6. The EFMP Case Coordinator notifies the Soldier of enrollment.

NOTE: Soldiers are responsible for ensuring that the EFMP enrollment information is current. Updates are required when a registered family member's special medical or education needs change, or at least every three years.

CONTACTS:

ATTN EFMP Case Coordinator

Nearest Army MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

FORMS:

- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

MARINE CORPS EFMP ENROLLMENT

1. The completed DD 2792 and/or DD 2792-1 forms are submitted to the local Military Treatment Facility (MTF), Installation EFMP Office, or HQMC, using the contact information listed below.
2. MTF staff or installation EFMP offices complete an administrative review of the documents prior to forwarding to HQMC.
3. Upon receipt, HQMC reviews the forms and documentation to determine medical and/or educational eligibility.
4. If eligible, HQMC enrolls Marine into the EFMP.
5. HQMC EFMP emails the enrollment eligibility letter to the Marine's government email account within two weeks of receipt of paperwork. If the Marine does not have a government email account, a letter will be mailed to the Marine's address listed on the Marine Corps Total Force System.

NOTE: Enrollees must update enrollment information every three years, or sooner, if there is a change in status for any family member enrolled in the EFMP.

CONTACTS:

Nearest MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

Email: HQMC.efmp@usmc.mil
Fax: 703-784-9821

USMC EFMP Staff end documents via AMRDEC SAFE Web Administration: https://safe.amrdec.army.mil/safe

FORMS:

- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

NAVY EFMP ENROLLMENT

1. The completed DD 2792 and/or DD 2792-1 forms and any applicable attachments are submitted to the EFMP Coordinator at the Military Treatment Facility (MTF), using the contact information listed below.
2. The EFMP Coordinator at the MTF conducts an administrative review of the forms.
3. Following the administrative review, the EFMP Coordinator forwards the application to the appropriate Central Screening Committee (CSC) via mail, fax, or the Navy Family Accountability Assessment System (NFAAS), using the contact information listed below.
4. The CSC reviews the enrollment forms to determine medical and/or educational eligibility, recommends an assignment category, and forwards the application to the Navy Personnel Command (PERS-451).
5. The Navy's EFMP Manager at PERS-451 reports enrollment to the officer and enlisted detailers and annotates the sponsor's personnel records in the EFMP database.
6. For proof of enrollment, the Active Duty sponsor must wait 5 to 7 days after submitting completed application via NFAAS or wait 4 to 6 weeks after submitting the completed application via regular mail; then, call the Navy Personnel Command (NPC) customer service center at 1-866-827-5672.

NOTE: Enrollees must update enrollment information every three years, 12 months prior to negotiating orders, 12 months prior to a Permanent Change of Station (PCS), and/or with a change of status of a family member enrolled in the EFMP.

CONTACTS:

Nearest MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

If family member lives east of the Mississippi River in the continental United States, Europe, Africa, South America, and the Caribbean:

Central Screening Committee (Code 60465C)
Exceptional Family Member Program
Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197
Commercial (757) 953-5900

If family member lives west of the Mississippi River in the continental United States and Alaska:

Department of the Navy
Naval Medical Center, Suite 100
34520 Bob Wilson Drive
San Diego, CA 92134-2100
Commercial (619) 532-6910

If family member lives in countries in the South Pacific, Asia, and Hawaii:

EFMP Central Screening Committee
U.S. Naval Hospital Yokosuka
PSC 475, Box 1, Code 121Y
FPO AP 96350-1600
Commercial011-81-6160-43-5379
DSN: 243-5379

FORMS:

- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

AIR FORCE EFMP ENROLLMENT

1. The completed DD 2792 and/or DD 2792-1 forms, any applicable attachments, and the AF 2523 form are submitted to the Airman's PAS-coded Air Force Medical Treatment Facility (MTF) to the attention of the Special Needs Coordinator (SNC), using the contact information listed below.
2. The SNC at the MTF conducts an administrative review of the forms.
3. Following the administrative review, the SNC reviews the forms to determine medical and/or educational eligibility.
4. If eligible for the EFMP, the SNC sends a letter to the Military Personnel Section (MPS).
5. The MPS Staff adds a Q-code to the Airman's record in MilPDS, designating enrollment in the EFMP.

NOTE: Airmen are responsible for ensuring that the EFMP enrollment information is current. Updates are required when a family member's medical or special education needs change.

CONTACTS:

ATTN Special Needs Coordinator

Nearest Airman's PAS-coded Air Force MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

FORMS:

- AF 2523 Exceptional Family Member Program-Medical (EFMP-M) Information Form
- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

B. INTRODUCTION TO EFMP FAMILY SUPPORT

EFMP family support assists families with special needs by helping them identify and access programs and services. EFMP family support includes, but is not limited to: information and referral for military and community services, non-clinical case management, the assessment of family needs, the development of an individualized Services Plan (SP), local school and Early Intervention Services (EIS) information, and warm handoffs when a family transfers to a new location.

While enrollment in the EFMP is mandatory for Active Duty Service members, EFMP family support will still provide services to Service members not enrolled in the EFMP and will help enroll families with special needs into the program.

CONTACTS:

Instructions to use the online search tool for EFMP Family Support contact information can be found on pages 16-17 in this guide. Additionally, family support contact information for each Service can be found in the Appendix, on pages 22-35 in this guide.

- EFMP Family Support Contact Information online search tool, pages 16-17
- Army Family Support Contact Information, pages 22-26
- Marine Corps Family Support Contact Information, page 27
- Navy Family Support Contact Information, pages 28-31
- Air Force Family Support Contact Information, pages 32-35

RESOURCES:

For further information about providing EFMP family support services please access the EFMP: Family Support Reference Guide.

C. INTRODUCTION TO FAMILY TRAVEL SCREENING

Family Travel Screening helps to ensure that Service members are assigned to locations that can support their families' needs.

Family Travel Screening is required for all families being considered for accompanied OCONUS assignments. The availability of medical and/or educational services to support the needs of EFMP families must be verified for all locations prior to travel approval. Depending on Service-specific guidance, Family Travel Screening may also be conducted for families enrolled in the EFMP for CONUS assignments.

As part of the Family Travel Screening process, the Service member and his/her family complete a medical and educational screening. When special needs are identified during the screening, enrollment in the EFMP should be initiated.

This section provides instructions to prepare families for the Family Travel Screening process for the Army, Marine Corps, Navy, and Air Force. Screening forms are listed on each page, as applicable, and copies of the screening forms can be located in the Appendix.

ARMY FAMILY TRAVEL SCREENING (OCONUS SCREENING)

1. The Soldier obtains the authenticated DA 5888 and DA 7246 from the losing Military Personnel Division (MPD) at the Levy Briefing.
2. The Soldier or spouse schedules an OCONUS screening appointment with the EFMP Case Coordinator at the nearest Army Medical Treatment Facility (MTF). **NOTE:** If necessary, Case Coordinator will assist the family in scheduling a screening at another DoD MTF.
3. The EFMP Case Coordinator conducts the screening appointment at that MTF.
4. A member of the EFMP staff reviews medical records of all family members, and if necessary, arranges for a physical and developmental screening for children 72 months of age and younger, and completes the medical portion of DA 5888.

   NOTE: If there is an educational concern, the Soldier or spouse will be asked to have the staff at the child's school or early intervention program complete the DD 2792-1 and attach a copy of the child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).
5. The MPD receives the completed DA 5888 with copies of DD 2792 and, if applicable, DD 2792-1 from the Soldier.
6. The MPD forwards the forms to the overseas travel approval authority and requests command sponsorship/family member travel.
7. As appropriate, the overseas travel approval authority coordinates with the Department of Defense Dependents School (DoDDS) and medical point-of-contact to determine availability of required services and provides decision to the MPD within thirty days.

NOTE: Soldiers who enroll in the EFMP after the receipt of OCONUS assignment instructions need to be aware that enrollment will not affect that assignment. If general medical care is not available, the Soldier may be required to serve an "all others" tour.

CONTACTS:

EFMP Case Coordinator

Nearest Army MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

FORMS:

- DA 5888 Family Member Deployment Screening Sheet
- DA 7246 EFMP Screening Questionnaire
- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

MARINE CORPS FAMILY TRAVEL SCREENING (OVERSEAS SUITABILITY SCREENING)

For Marine Corps Family Travel Screening, please reference the Navy Family Travel Screening on page 11 in this guide.

NAVY FAMILY TRAVEL SCREENING (OVERSEAS SUITABILITY SCREENING)

1. The Sailor schedules an appointment with the Suitability Screening Coordinator (SSC) at the losing Military Treatment Facility (MTF) for an Overseas Suitability Screening (OSS). **NOTE:** Required for assignments covering both OCONUS and designated CONUS Remote Duty Locations.
2. The MTF SSC conducts the preliminary review and completes the NAVMED 1300/2 for each Sailor and family member.
3. A medical provider conducts the screening and completes the NAVMED 1300/1, PART I and II for each Sailor and family member.
4. If a special need is identified and a suitability inquiry is required, the SSC at the losing MTF forwards the inquiry to the gaining MTF.
5. The SSC at the gaining MTF will determine local healthcare, Educational and Developmental Intervention Services (EDIS), and/or Department of Defense Dependents Schools (DoDDS) capabilities and will respond to the losing MTF within 7 working days.
6. The MTF Commanding Officer or Officer in Charge reviews NAVMED 1300/1, PART I and II and completes and signs NAVPERS 1300/16, PART II.
7. The Transferring Command makes a suitability determination based on the MTF recommendation by completing and signing NAVPERS 1300/16, PART I.

NOTE: Screening and EFMP enrollment may proceed concurrently, but screening must be completed before the sponsor reports to the new duty location. Families with special needs who were not enrolled in the EFMP prior to receiving orders may not be authorized to obtain command-sponsored travel for family members if the gaining MTF determines that general medical services required by any family member are not available.

CONTACTS:

Nearest Navy MTF and DTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

FORMS:

- NAVMED 1300/1 Medical, Dental and Educational Suitability Screening for Service and Family Members
- NAVMED 1300/2 Medical, Dental, and Educational Suitability Screening Checklist and Worksheet
- NAVPERS 1300/16 Report of Suitability for Overseas Assignment

AIR FORCE FAMILY TRAVEL SCREENING (FAMILY MEMBER RELOCATION CLEARANCE)

1. The Airman attends an Exit Briefing with the Military Personnel Section (MPS)/ Military Personnel Function (MPF) Staff with a completed AF 4380 to determine the need for family screening.
2. If screening is required, the Airman schedules the Family Member Relocation Clearance (FMRC) appointment.
3. The Airman arrives at the scheduled FMRC appointment with the completed forms, AF 1466, AF 1466D, and DD 2792 and/or DD 2792-1.
4. The FMRC Coordinator (FMRCC) conducts an administrative review of the forms for accuracy, obtains the medical records/documents, and determines if screening is required.
5. If required, the FMRCC schedules a screening appointment.

   NOTE: For OCONUS travel, the Airman and all accompanying family members' records/documents are screened. For CONUS travel, only family members with special educational and/or medical needs are screened.
6. The Airman and family attend a joint screening appointment at the MTF with the Special Needs Coordinator (SNC) and Medical Review Officer (MRO).
7. If special needs are identified, the FMRCC develops a Facility Determination Inquiry (FDI) package, which includes the completed AF 1466, AF 1466D, DD 2792 and/or DD 2792-1 forms, signed by the SNC, MRO, Surgeon General of the Hospital (SGH), and/or medical providers.
8. If special needs are not identified, the AF 1466 is signed by the SNC, MRO, SGH, and or medical provider and Airman. Proceed to step 11.
9. The gaining MTF reviews the FDI package and determines if the base community can meet special needs.
10. If the base community can meet the family's needs, the finalized FDI is returned to FMRCC at the losing base.
11. The AF 1466 is forwarded to MPS/MPF Outbound Assignments and Orders are issued.

NOTE: If family is denied travel, then the Airman may agree to travel unaccompanied and the Orders are issued. The Airman may also submit an EFMP Reassignment/Deferment Request in Virtual Military Personnel Flight (vMPF) within 10 days to be considered for another assignment, depending on the needs of the Air Force.

CONTACTS:

ATTN: FMRC Coordinator
Nearest Airman's PAS-coded Air Force MTF (Search)

NOTE: Instructions to use the TRICARE MTF Locator can be found on pages 18-20 of this guide.

FORMS:

- AF 1466 Family Member Relocation Checklist
- AF 1466D Dental Health Summary
- AF 4380 Air Force Special Needs Screener
- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

D. INTRODUCTION TO EFMP CONTACT INFORMATION

Three search tools allow you to locate the contact information for EFMP Enrollment, TRICARE Military Treatment Facilities, and EFMP Family Support available online.

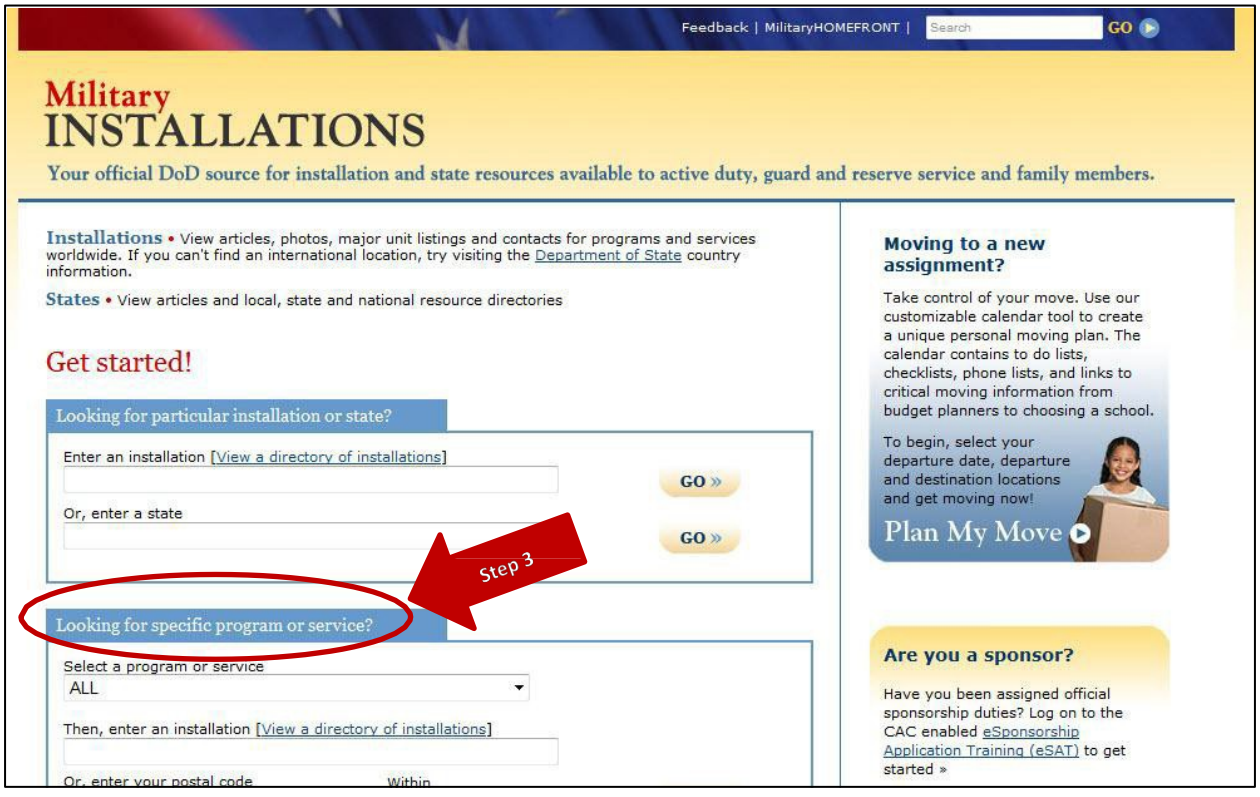
This section provides instructions to use the EFMP Enrollment, TRICARE Military Treatment Facility Locator, and EFMP Family Support search tools.

EFMP ENROLLMENT CONTACT INFORMATION

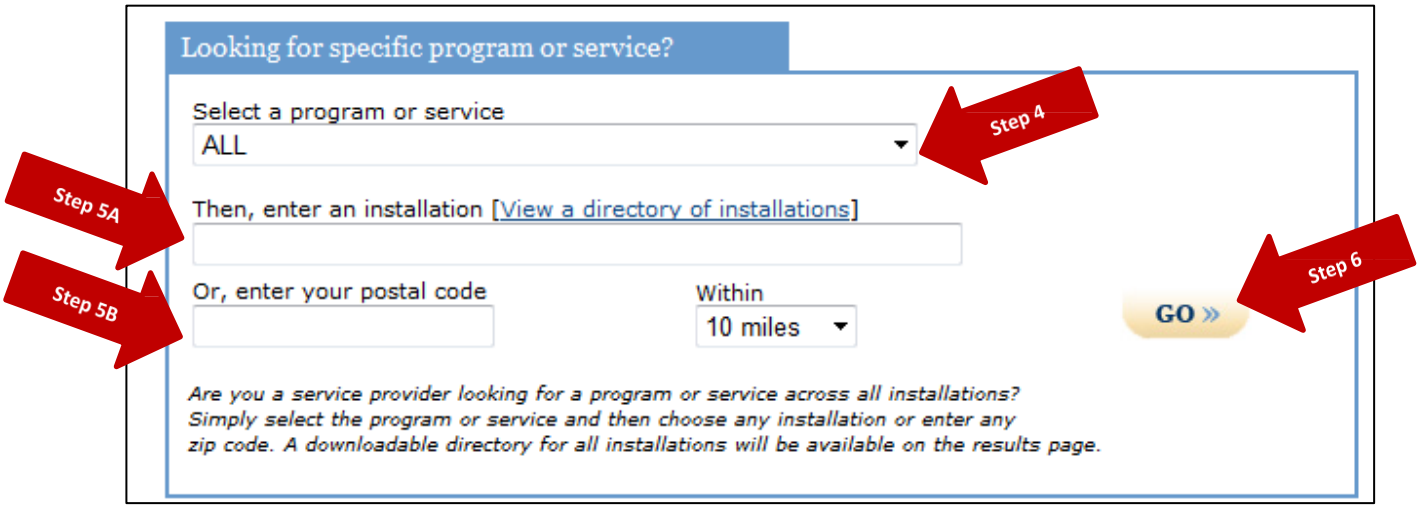
1. Open your Internet Browser (for example, Internet Explorer).
2. Type the following **web address** into your Internet browser: www.militaryinstallations.dod.mil/

   Enter the **web address** in the **address bar**, as shown below (Step 2 Arrow):

3. This will bring you to the Military Installations homepage, displayed below. Locate the "**Looking for specific program or service?**" box (Step 3 Arrow).



4. In the **Looking for specific program or service?** box (*shown below*), select **EFMP-Enrollment** in the drop down menu under "Select a program or service," (Step 4 Arrow).
5. Then, **enter your installation** in the field displayed (Step 5A Arrow) or **enter your postal code** in the field displayed (Step 5B Arrow) to find EFMP Enrollment information for your installation.
6. Click **"Go"** to view results (Step 6 Arrow).

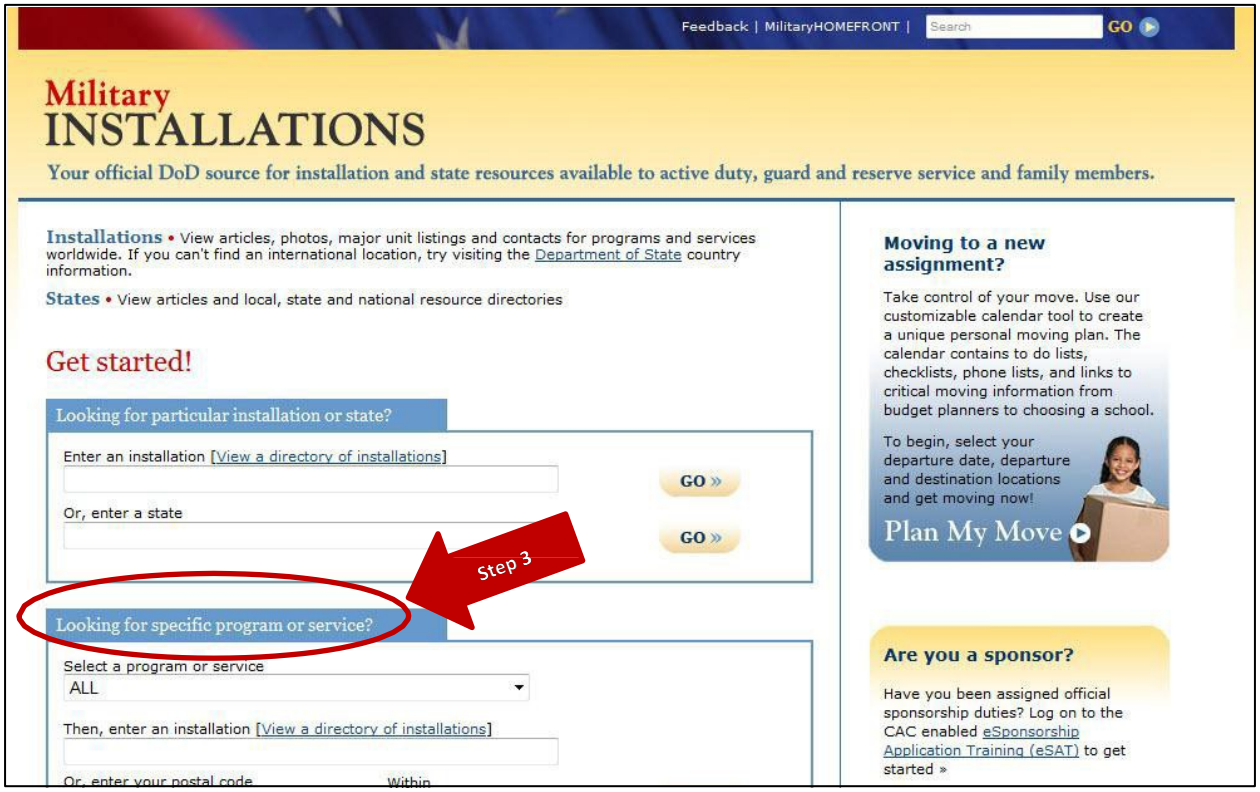


EFMP FAMILY SUPPORT CONTACT INFORMATION

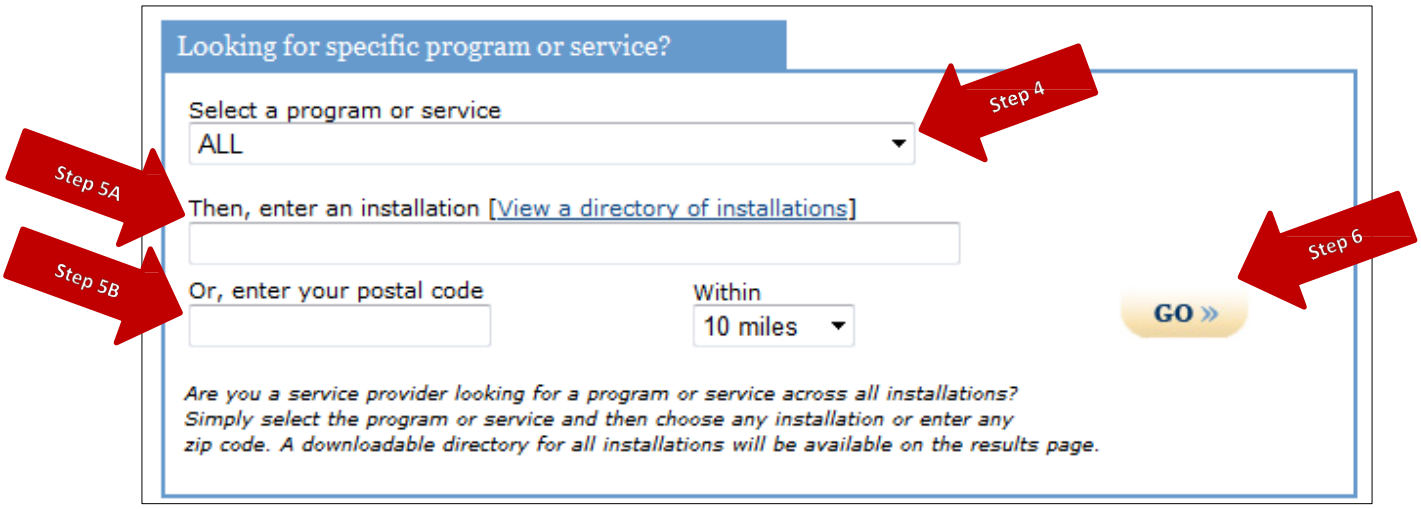
1. Open your Internet Browser (for example, Internet Explorer).
2. Type the following **web address** into your Internet browser: www.militaryinstallations.dod.mil/

   Enter the **web address** in the **address bar**, as shown below (Step 2 Arrow):

3. This will bring you to the Military Installations homepage, displayed below. Locate the "**Looking for specific program or service?**" box (Step 3 Arrow).



4. In the **Looking for specific program or service?** box (*shown below*), select **EFMP-Family Support** in the drop down menu under "Select a program or service," (Step 4 Arrow).
5. Then, **enter your installation** in the field displayed (Step 5A Arrow) or **enter your postal code** in the field displayed (Step 5B Arrow) to find EFMP Family Support information for your installation.
6. Click **"Go"** to view results (Step 6 Arrow).



TRICARE MILITARY TREATMENT FACILITY CONTACT INFORMATION

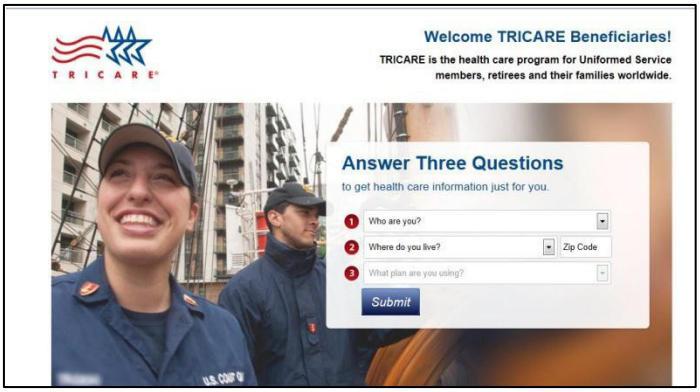
If you are familiar with the TRICARE website, go to www.tricare.mil/mtf and skip to Step 8. Otherwise, please start with Step 1.

1. Open your Internet Browser (for example, Internet Explorer).
2. Type the following **web address** into your Internet browser: www.tricare.mil

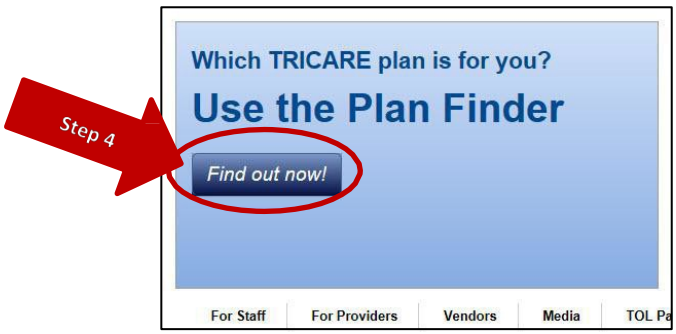
   Enter the **web address** in the **address bar**, as shown below (Step 2 Arrow):

3. This will bring you to the TRICARE homepage (displayed below).

   NOTE: The website image will not always match the picture below due to rotating background image on the home screen.

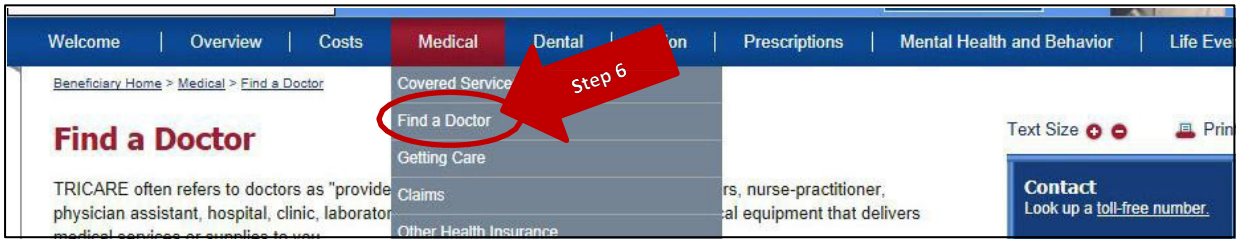


4. Locate the "**Which TRICARE plan is for you?**" box (displayed below) and click the "**Find out now!**" link (Step 4 Arrow).

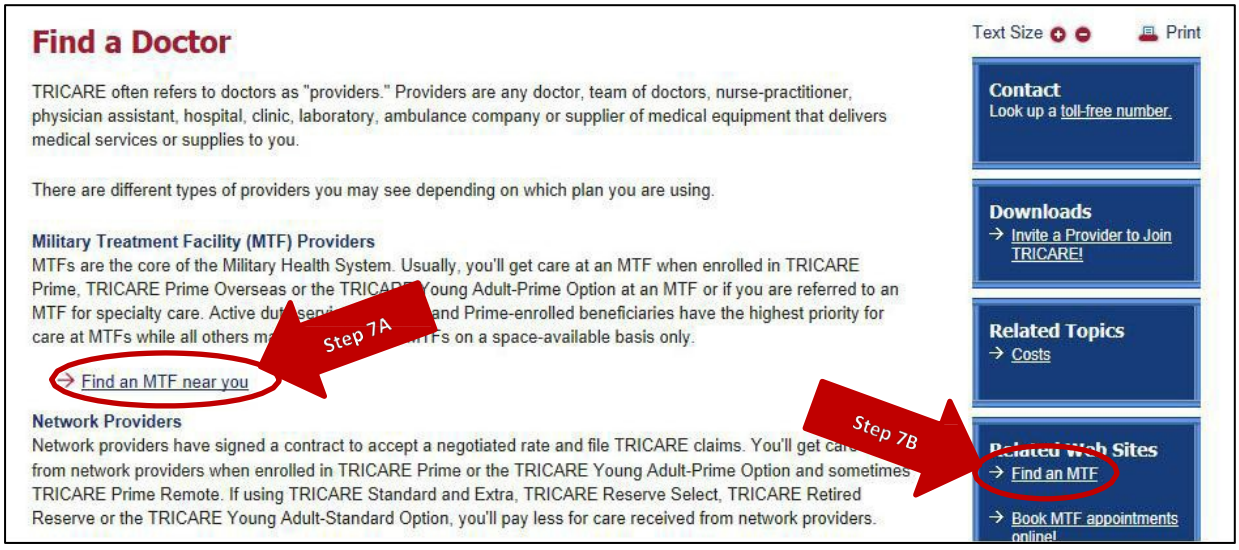


5. This will bring you to the Overview page (displayed below). Locate the **Medical** tab (Step 5 Arrow).

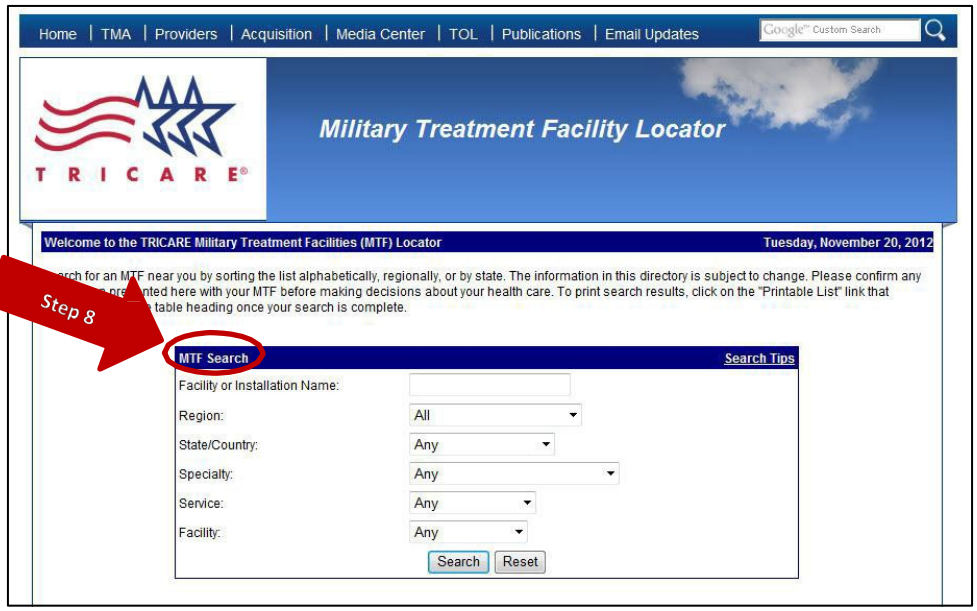
6. In the Medical drop down menu, click "**Find a Doctor**" (Step 6 Arrow).



7. This will bring you to the Find a Doctor page, displayed below. Please click on one of the two Military Treatment Facility links, either "**Find an MTF near you**" (Step 7A Arrow) or "**Find an MTF**" (Step 7B Arrow).



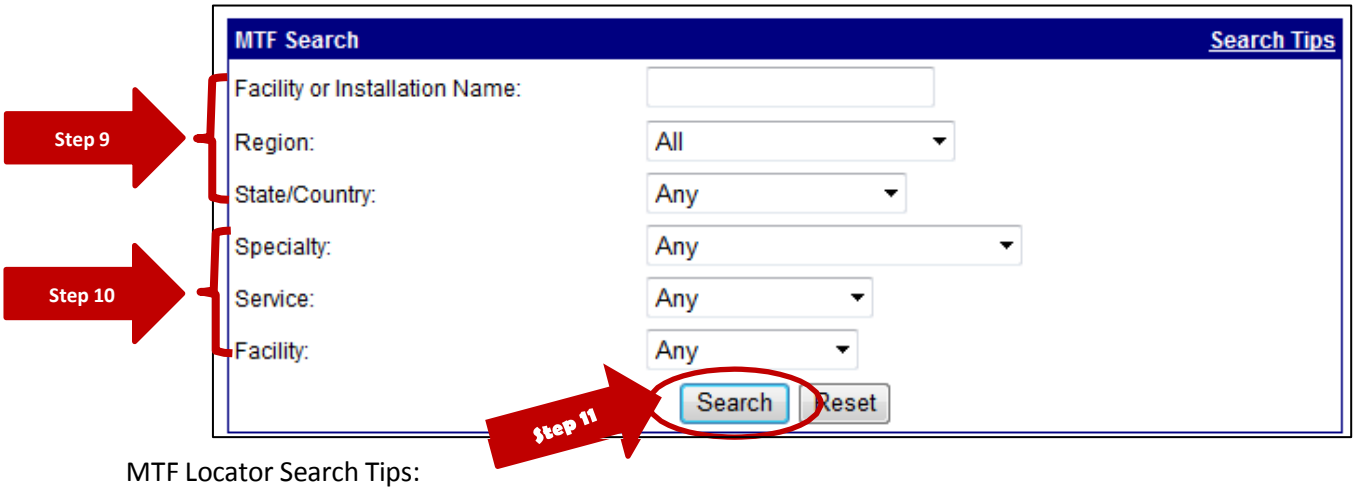
8. This will bring you to the TRICARE Military Treatment Facility (MTF) homepage, displayed below. Locate the "**MTF Search**" box (Step 8 Arrow).



9. In the MTF Search box (displayed below), search for a MTF by entering your **Facility or Installation Name, Region,** and/or **State/Country** (Step 9 Arrow).

Use the **Specialty, Service,** and/or **Facility** options to narrow your search (Step 10 Arrow).

Click "**Search**" to view results (Step 11 Arrow).



MTF Locator Search Tips:

- When searching for Facility Name or Installation Name, the search will find ALL of the words that you enter. For example, naval health will find anything containing the word naval and health.
- Do not use abbreviations, for example, ft. instead of Fort. Using abbreviations will reduce the accuracy of the search. If you would like to search for a phrase, use quotation marks. For example, "Walter Reed" will find anything containing the phrase Walter Reed.

E. APPENDIX: INTRODUCTION TO FAMILY SUPPORT CONTACT INFORMATION

This section contains Family Support contact information for Army, Marine Corps, Navy, and Air Force installations. The information can be used to learn more about an installation or to contact Family Support Staff when a family is moving to a new location.

Note: If for any reason the provided links do not work, please visit the Military One Source website (http://www.militaryonesource.mil/) and search the Service or installation of your choice for available Family Support information.

ARMY FAMILY SUPPORT CONTACT INFORMATION

IMCOM

INSTALLATION	PHONE
IMCOM G-9	210-466-1137
HQ, DIRECT REPORTING UNIT (DRU)	210-466-1154
Fort Belvoir, VA	703-805-3436
Fort Leavenworth, KS	913-684-2838
Fort Hamilton, NY	718-630-4460
Carlisle Barracks, PA	717-245-3775
Fort Detrick, MD	301-619-3385
Fort Meade, MD	301-677-5590
USAG Miami, FL	305-437-2734
West Point, NY	845-938-5655
Presidio of Monterey, CA	831-242-7960
Joint Base Myer- Henderson Hall, VA	703-696-3510

IMCOM CENTRAL

INSTALLATION	PHONE
IMCOM CENTRAL	210-295-2188
Fort Bliss, TX	915-569-4227
Fort Carson, CO	719-526-4590
Detroit Arsenal, MI	586-282-0475
Dugway Proving Ground, UT	435-831-2834

IMCOM CENTRAL, cont.

INSTALLATION	PHONE
Fort Hood, TX	254-287-6070
Fort Huachuca, AZ	520-533-6871
NTC/Fort Irwin, CA	760-380-3698
Fort Leonard Wood, MO	573-596-0212
Fort Polk, LA	337-531-2840
Fort Riley, KS	785-239-9435
Rock Island Arsenal, IL	309-782-4736
Fort Sill, OK	580-442-4916
White Sands Missile Range, NM	575-678-6767
Yuma Proving Ground, AZ	928-328-3224
Joint Base Lewis- McChord, WA	253-967-9704
Joint Base San Antonio, TX	210-916-5721
Fort McCoy (USAR), WI	608-388-3505
CSTC, Fort Hunter Liggett (USAR), CA	831-386-2378

IMCOM ATLANTIC

INSTALLATION	PHONE
IMCOM ATLANTIC	757-501-8173
Aberdeen Proving Ground, MD	410-278-2420
Anniston Army Depot, AL	256-235-7971

IMCOM ATLANTIC, cont.

INSTALLATION	PHONE
Fort Benning, GA	706-545-5521
Fort Bragg, NC	910-907-3395
Fort Campbell, KY	270-798-2727
Fort Drum, NY	315-772-5476
Fort Gordon, GA	706-791-4872
Fort Jackson, SC	803-751-5256
Fort Knox, KY	502-624-5419
Fort Lee, VA	804-734-6393
Natick, MA	508-233-5377
Picatinny Arsenal, NJ	973-724-2145
Redstone Arsenal, AL	256-876-5397
Fort Rucker, AL	334-255-9277
Fort Stewart, GA	912-767-5058
Tobyhanna Army Depot, PA	570-615-7069
Joint Base McGuire- Dix- Lakehurst (Air Force), NJ	609-754-2023
Joint Base Langley-Eustis (Air Force), VA	757-878-1954
Joint Base Little Creek-Story (Navy), VA	757-462-7563
Fort Buchanan (USAR), PR	787-707-3295
Fort Devens (USAR), MA	978-796-3023

EUROPE REGION

INSTALLATION	PHONE
EUROPE REGION	49-6302-67-5627
USAG Ansbach, Germany	49-9802-83-3629
USAG Bamberg, Germany	49-951-300-8397
USAG Schweinfurt, Germany	49-9721-96-61207/6933
USAG Kaiserslautern, Germany	49-631-3406-4094
USAG Benelux, Belgium	32-65-44-7461
USAG Brussels, Belgium	32-2-717-9725
USAG Schinnen, Netherlands	31-46-443-7453/7269
USAG Grafenwoehr, Germany	49-9662-83-2881
USAG Hohenfels, Germany	49-9472-83-4907
USAG Garmisch, Germany	49-8821-750-3572
USAG Stuttgart, Germany	49-7031-15-3344
USAG Vicenza, Italy	39-0444-71-8582
Darby Army Community (Livorno), Italy	39-50-54-7486
USAG Wiesbaden, Germany	49-611-408-5234
USAG Baumholder, Germany	49-678368184/678368188

IMCOM PACIFIC

INSTALLATION	PHONE
IMCOM PACIFIC	808-438-5492
USAG Daegu, South Korea	011-82-53-470-8329
Fort Greely, AK	907-873-4385
USAG Schofield Barracks, HI	808-655-4385
USAG Camp Zama, Japan	011-81-46-407-4572
USAG Torii Station, Japan	011-81-611-744-4106
USAG Red Cloud/Camp Casey, South Korea	011-8231-869-4805
Fort Wainwright, AK	907-353-4243
Joint Base Elmendorf- Richardson (Air Force), AK	907-384-0225
USAG Yongsan, South Korea	011-822-7918-5311
USAG Humphreys, South Korea	011-8231-690-3742

MARINE CORPS FAMILY SUPPORT CONTACT INFORMATION

INSTALLATION	PHONE
HQMC EFMP, VA	703-784-0298
Twentynine Palms, CA	760-830-7740
Albany, GA	229-639-5277
Barstow, CA	760-577-6287
Beaufort/MCRD Parris Island, SC	843-228-2041
Camp Butler Okinawa, Japan	011-81-611-745-9237
Camp Lejeune, NC	910-451-9372
Camp Pendleton, CA	760-725-1966
Cherry Point, NC	252-466-7547
Hawaii	808-257-7773
Henderson Hall, VA	703-693-6368
Iwakuni, Japan	011-81-827-79-5601
MCRD San Diego, CA	619-524-6078
Miramar, CA	858-577-8644
New River, NC	910-449-5248
Quantico, VA	571-931-0525
Yuma, AZ	928-269-2425
Camp Allen, VA	757-445-6875

NAVY FAMILY SUPPORT CONTACT INFORMATION

COMMAND: CNRSW

INSTALLATION	PHONE
Navy Region Southwest	619-556-7404
China Lake, CA	760-939-4545
Monterey, CA	831-656-3060
El Centro, CA	760-339-2442
Fallon, NV	775-426-3333
Lemoore, CA	559-998-4042
Ventura County/Point Mugu, CA	805-982-5037
San Diego, CA	619-556-7404
Murphy Canyon, CA	858-277-4259
Coronado, CA	619-545-6071

COMMAND: CNR HAWAII

INSTALLATION	PHONE
Joint Base Pearl Harbor-Hickam, HI	808-474-1999 x6108

COMMAND: CNR MID-ATLANTIC

INSTALLATION	PHONE
Navy Region Mid- Atlantic	757-322-9109
Newport, RI	401-841-2283

COMMAND: CNR MID-ATLANTIC cont.

INSTALLATION	PHONE
New London, CT	860-694-3383
Earle, NJ	732-866-2115
Saratoga Springs, NY	518-886-0200
Portsmouth NSY, ME	207-438-1835
Norfolk, VA	757-444-2102
JEB Little Creek Fort Story, VA	757-462-7563
Oceana, VA	757-433-2912
Yorktown/Newp ort News, VA	757-887-4606
Portsmouth, VA	757-444-2102
Sugar Grove, WV	304-249-6519
NSA Norfolk Northwest Annex, VA	757-421-8770

COMMAND: CNEURAFSWA

INSTALLATION	PHONE
CNR EURAFSWA	011-39-081-568-6951
Naples, Italy	011-39-081-811-6372
Souda Bay, Greece	011-30-28210-21690
Rota, Spain	011-34-356-82-3232
Sigonella, Italy	011-39-095-56-4291
Bahrain, Kingdom of Bahrain	011-973-1785-4046

COMMAND: CNRSE

INSTALLATION	PHONE
Navy Region Southeast	904-542-9838
Corpus Christi, TX	361-961-2372
Gulfport, MS	228-871-2581
Guantanamo Bay, Cuba	011-5399-4141
Jacksonville, FL	904-542-5745
Key West, FL	305-293-4408
Kingsville, TX	361-516-6333
Meridian, MS	601-679-2360
Pensacola, FL	850-452-5990
JRB Forth Worth, TX	817-782-5287
JB Charleston (Air Force Supported), SC	843-963-4406
Mayport, FL	904-270-6600
JRB New Orleans, LA	504-678-7569
Panama City, FL	850-235-5800
Kings Bay, GA	912-573-4512
Whiting Field, FL	850-623-7177

COMMAND: CNRNW

INSTALLATION	PHONE
Navy Region Northwest (NAVBASE KITSAP, WA)	360-396-4115
Naval Station Everett, WA	425-304-3735
Smokey Point, WA	425-304-3367
NAS Whidbey Island, WA	360-257-6289

COMMAND: CNR JAPAN

INSTALLATION	PHONE
Diego Garcia	011-246-3704421
Atsugi, Japan	81-467-63-3628
Sasebo, Japan	011-81-956-50-3112
Yokosuka, Japan	046-8163372/6716

COMMAND: CNR MARIANAS

INSTALLATION	PHONE
Guam	671-333-2056

COMMAND: CNR MIDWEST

INSTALLATION	PHONE
NSA Mid-South	901-874-5075
Naval Station Great Lakes, IL	847-688-3603

COMMAND: NAVAL DISTRICT WASHINGTON (NDW)

INSTALLATION	PHONE
Naval District Washington	202-433-6235
NSA Annapolis, MD	410-293-2641
NAS Patuxent River, MD	301-342-4911
NSA Bethesda, MD	301-319-4087
JB Anacostia- Bolling, DC	202-433-6151 202-767-0450
NSA South Potomac, DC (Dahlgren, VA)	540-653-1839
Naval Support Facility Indian Head, MD	800-500-4947

AIR FORCE FAMILY SUPPORT CONTACT INFORMATION

MAJCOM: ACC

INSTALLATION	PHONE
Beale, CA	530-634-2863
Davis Monthan, AZ	520-228-5690
Dyess, TX	325-696-5999
Ellsworth, SD	605-385-4663
Holloman, NM	575-572-7754
Joint Base Langley- Eustis (Langley), VA	757-764-3990
Joint Base Langley- Eustis (Eustis), VA	757-878-1954
Moody, GA	229-257-4789
Mt Home, ID	208-828-2458
Nellis, NV	702-652-3327
Offutt, NE	402-294-4329
Seymour Johnson, NC	919-722-1123
Shaw, SC	803-895-1163

MAJCOM: AETC

INSTALLATION	PHONE
Altus, OK	580-481-7922
Columbus, MS	662-434-2701
Joint Base San Antonio - Fort Sam Houston, TX	210-221-9826
Goodfellow, TX	325-654-3893

MAJCOM: AETC, cont.

INSTALLATION	PHONE
Keesler, MS	228-376-8505
Joint Base San Antonio - Lackland, TX	210-671-3722
Laughlin, TX	830-298-4788
Luke, AZ	623-856-6378
Maxwell, AL	334-953-3799
Joint Base San Antonio - Randolph, TX	210-652-5321
Sheppard, TX	940-676-4358
Tyndall, FL	850-283-4204
Vance, OK	580-213-6330

MAJCOM: AFDW

INSTALLATION	PHONE
Andrews, MD	301-981-7088
Pentagon, VA	703-693-9460

MAJCOM: AFGSC

INSTALLATION	PHONE
Barksdale, VA	318-456-8400
FE Warren, WY	307-773-5943
Malmstrom, MT	406-731-4900
Minot, ND	701-723-3950
Whiteman, MO	660-687-7132

MAJCOM:AFGSC cont…

INSTALLATION	PHONE
Edwards, CA	661-277-0723
Eglin, FL	850-883-4342
Hanscom, MA	781-225-2765
Hill, UT	801-586-2611
Kirtland, NM	505-853-1717
Warner Robins, GA	478-926-1259
Tinker, OK	405-734-5690
Wright Patterson, OH	937-656-0946

MAJCOM: AFSOC

INSTALLATION	PHONE
Cannon, NM	575-784-4228
Hurlburt Field, FL	850-884-6830

MAJCOM: AFSPC

INSTALLATION	PHONE
Buckley, CO	720-847-9038
Los Angeles, CA	310-653-5193
Patrick, FL	321-494-5676
Peterson, CO	719-556-0458
Schriever, CO	719-567-3920
Vandenberg, CA	805-606-0039

MAJCOM: AMC

INSTALLATION	PHONE
Joint Base Charleston, SC	843-963-4411
Dover, DE	302-677-6383
Fairchild, WA	509-247-2246
Grand Forks, ND	701-747-6434
Little Rock, AR	501-987-8480
MacDill, FL	813-828-0122
McConnell, KS	316-759-3182
Joint Base McGuire- Dix- Lakehurst, NJ	609-754-2023
Pope, NC	910-394-2538
Scott, IL	618-256-8668
Travis, CA	707-424-4342

MAJCOM: PACAF

INSTALLATION	PHONE
Eielson, AK	907-377-2178
Joint Base Elmendorf- Richardson, AK	907 552-0671
Joint Base Elmendorf- Richardson, AK	907 384-0225
Kadena, Japan	011-81-98-961-3366
Misawa, Japan	011-81-317-77-4735
Osan, Korea	011-82-31-661-5440
Yokota, Japan	011-81-311-755- 8725

MAJCOM: USAFA

INSTALLATION	PHONE
AF Academy, CO	719-333-3444

MAJCOM: USAFE

INSTALLATION	PHONE
Aviano, Italy	0434-30-5747
Morón, Spain	39-0434305407
RAF Alconbury, England	44-1480843470
Geilenkirchen, Germany	49-2451633791
Incirlik, Turkey	90-322-3166755
Lajes Field, Azores	351-295574138
RAF Lakenheath, England	44-1638523847
RAF Menwith Hill, England	44-1423-777730
RAF Mildenhall / RAF Croughton, England	44-1638543406
Ramstein, Germany	49-6371475100
Spangdahlem, Germany	49-6565616422

F. APPENDIX: INTRODUCTION TO EFMP FORMS

Forms are required for enrollment into the EFMP and for the Family Travel Screening process. In this section you will find forms for the Army, Marine Corps, Navy, and Air Force. The Department of Defense forms are required for enrollment into the EFMP for all Services.

DEPARTMENT OF DEFENSE FORMS

ENROLLMENT

- DD 2792 Family Member Medical Summary
- DD 2792-1 Special Education/Early Intervention Summary

ARMY FORMS

FAMILY TRAVEL SCREENING

- DA 5888 Family Member Deployment Screening Sheet
- DA 7246 EFMP Screening Questionnaire

MARINE CORPS / NAVY FORMS

FAMILY TRAVEL SCREENING

- NAVMED 1300/1 Medical, Dental and Educational Suitability Screening for Service and Family Members
- NAVMED 1300/2 Medical, Dental, and Educational Suitability Screening Checklist and Worksheet
- NAVPERS 1300/16 Report of Suitability for Overseas Assignment

AIR FORCE FORMS

ENROLLMENT

- AF 2523 Exceptional Family Member Program-Medical (EFMP-M) Information Form

FAMILY TRAVEL SCREENING

- AF 1466 Family Member Relocation Checklist
- AF 1466D Dental Health Summary
- AF 4380 Air Force Special Needs Screener

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)*

- ☐ ARMY
- ☐ AIR FORCE
- ☐ NAVY
- ☐ MARINE CORPS

e. STATUS *(X one)*

- ☐ REGULAR ACTIVE SERVICE MEMBER
- ☐ RESERVIST
- ☐ CIVILIAN
- ☐ 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 MEMBE
- ☐ 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. 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. ACTIVE 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)*	(1) CARE PROVIDER *(X as appropriate)*			(2) FREQUENCY
C01		a. ALLERGIST/IMMUNOLOGIST		C56		gg. OTORHINOLARYNGOLOGIST	
C52		b. AUDIOLOGIST		C47		hh. ORTHOPEDIC SURGEON - ADULT	
C42		c. CARDIAC/THORACIC SURGEON		C48		ii. ORTHOPEDIC SURGEON - PEDIATRIC	
C02		d. CARDIOLOGIST - ADULT		C77		jj. PAIN CLINIC	
C03		e. CARDIOLOGIST - PEDIATRIC		C72		kk. PEDIATRIC NURSE PRACTITIONER	
C70		f. CLEFT PALATE TEAM - PEDIATRIC		C30		ll. PEDIATRICIAN	
C05		g. DERMATOLOGIST		C49		mm. PEDIATRIC SURGEON	
C06		h. DEVELOPMENTAL PEDIATRICIAN		C32		nn. PHYSIATRIST *(Physical Rehabilitation)*	
C53		i. DIALYSIS TEAM		C58		oo. PHYSICAL THERAPIST	
C07		j. DIETARY/NUTRITION SPECIALIST		C50		pp. PLASTIC SURGEON - ADULT	
C08		k. ENDOCRINOLOGIST - ADULT		C71		qq. PLASTIC SURGEON - PEDIATRIC	
C09		l. ENDOCRINOLOGIST - PEDIATRIC		C35		rr. PSYCHIATRIST - ADULT	
C10		m. FAMILY PRACTITIONER		C36		ss. PSYCHIATRIST - PEDIATRIC	
C11		n. GASTROENTEROLOGIST - ADULT		C72		tt. PSYCHIATRIST NURSE PRACTITIONER	
C12		o. GASTROENTEROLOGIST - PEDIATRIC		C37		uu. PSYCHOLOGIST - ADULT	
C43		p. GENERAL SURGEON		C38		vv. PSYCHOLOGIST - PEDIATRIC	
C14		q. GENETICS		C33		ww. PULMONOLOGIST - ADULT	
C15		r. GYNECOLOGIST		C76		xx. PULMONOLOGIST - PEDIATRIC	
C17		s. HEMATOLOGIST/ONCOLOGIST - ADULT		C60		yy. RESPIRATORY THERAPIST	
C18		t. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C39		zz. RHEUMATOLOGIST - ADULT	
C75		u. INFECTIOUS DISEASE		C40		aaa. RHEUMATOLOGIST - PEDIATRIC	
C20		v. INTERNIST		C61		bbb. SOCIAL WORKER	
C21		w. NEPHROLOGIST - ADULT		C62		ccc. SPEECH AND LANGUAGE PATHOLOGIST	
C22		x. NEPHROLOGIST - PEDIATRIC		C41		ddd. TRANSPLANT TEAM	
C23		y. NEUROLOGIST - ADULT		C51		eee. UROLOGIST - ADULT	
C24		z. NEUROLOGIST - PEDIATRIC		C78		fff. UROLOGIST - PEDIATRIC	
C44		aa. NEUROSURGEON		C99		ggg. OTHER *(Describe)*	
C54		bb. OCCUPATIONAL THERAPIST - ADULT					
C55		cc. OCCUPATIONAL THERAPIST - PEDIATRIC					
C26		dd. OPHTHALMOLOGIST - ADULT					
C27		ee. OPHTHALMOLOGIST - PEDIATRIC					
C57		ff. ORAL SURGEON					

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

- GASTROSTOMY
- TRACHEOSTOMY
- CSF SHUNT
- CYSTOSTOMY
- COLOSTOMY
- ILEOSTOMY
- OTHER UNSPECIFIED PROSTHETICS *(Specify)*
- 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			

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
☐ OTHER *(Specify)*
☐ PERVASIVE DEVELOPMENTAL DISORDER/NOS

b. AGE WHEN DIAGNOSED

3. DATE OF BIRTH *(YYYYMMDD)*

c. DIAGNOSED BY:

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

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

☐ CHROMOSOMAL ABNORMALITIES
☐ OBSESSIVE COMPULSIVE DISORDER
☐ ATTENTION DEFICIT/HYPERACTIVITY DISORDER
☐ INTERMITTENT EXPLOSIVE DISORDER
☐ CIRCADIAN-RHYTHM SLEEP DISORDER
☐ GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS
☐ MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS
☐ SEIZURE DISORDER
☐ 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
☐ 50 - 70
☐ >70
☐ UNKNOWN
☐ INDETERMINATE

11. EDUCATION *(X)*

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

12. REQUIRED MEDICAL SERVICES *(X)*

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

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

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)*

- ☐ Regular Active Service Member
- ☐ Active Guard/Reserve Program (AGR)
- ☐ Reservist
- ☐ National Guard
- ☐ Civilian

d. BRANCH OF SERVICE *(Military only)*

- ☐ 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)*

STAMP

a. SPONSOR SSN

b. SPOUSE SSN *(If dual military)*

c. SSN USED IN DEERS *(If different from sponsor's)*

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.	g. COMMENTS
		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)*	

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)*

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.

PRINCIPAL PURPOSE: Personnel support.

ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER *(Last, first, MI)*	2. SOCIAL SECURITY NUMBER 3a. RANK		3b. MOS/BRANCH
4a. HOME ADDRESS	5a. DUTY ADDRESS		6. DATE OF EDAS CYCLE OR RFO *(OFF)* DATE
4b. HOME PHONE NO. *(Include Area Code)*	5b. DUTY PHONE NO. a. DSN b. COMMERCIAL *(Include area code)*		

7. FAMILY MEMBERS

a. NAME	b. RELATIONSHIP	c. DOB *(YYYYMMDD)*	d. HOME ADDRESS

8. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK *(Grade)*	d. SIGNATURE
b. TITLE		e. DATE *(YYYYMMDD)*

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM *(EFMP)* ENROLLMENT *(Check one)*				
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED *(Date sent for Coding)*	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT		
			NO	YES	DATE SENT FOR CODING

1 0. ARMY MEDICAL TREATMENT FACILITY *(MTF)* EFMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE *(YYYYMMDD)*
d. ADDRESS	e. PHONE NUMBER *(Include Commercial and DSN)*	

1 1. ARMY MTF EFMP PHYSICIAN'S AUTHENTICATION *(To be signed when a medical practitioner other than a physician completes this form.)*

a. TYPED OR PRINTED NAME OF PHYSICIAN	b. TITLE c. RANK	
d. SIGNATURE	e. DATE *(YYYYMMDD)*	

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

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 seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of 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 NAME/RANK		DATE *(YYYYMMDD)*
BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
	HOME ADDRESS	DUTY ADDRESS
PROJECTED PCS DATE		

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP
				☐
				☐
				☐
				☐
				☐

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

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. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME OF MEDICAL TREATMENT FACILITY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

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 seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of 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 NAME/RANK		DATE *(YYYYMMDD)*
BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

LIST ALL FAMILY MEMBERS	FAMILY MEMBER PREFIX	SEX	DATE OF BIRTH *(YYYYMMDD)*	CHECK IF ENROLLED IN EFMP
				☐
				☐
				☐
				☐
				☐

PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY

MEDICAL

1. Do any family members, excluding service member, have any medical records *(civilian or military)* other than the records you have provided us to screen? If yes, please list conditions/services received and address of provider. YES ☐ NO ☐

FAMILY MEMBER	CONDITIONS/SERVICES	NAME/ADDRESS OF PROVIDER

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. YES ☐ NO ☐

NAME	REASON

3. Are any members of your family, excluding service member, currently receiving medical *(includes mental health)* or educational services from any providers other than a general practitioner or family practice physician? YES ☐ NO ☐

4. Are any family members, excluding service member, taking any prescribed medication other than birth control pills on a regular basis? YES ☐ NO ☐

NAME	PRESCRIBED MEDICATION

5. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Problems with sight *(other than corrected by glasses)*			g.	Asthma, allergies or other respiratory problems		
b.	Problems with hearing			h.	Cerebral Palsy		
c.	Heart condition			i.	Delayed Speech		
d.	Seizure disorder			j.	Sickle Cell Trait/Disease		
e.	Loss of mobility *(requiring use of a wheelchair/ walker or aid in mobility)*	☐	☐	k.	Cancer		
				l.	High blood pressure		
f.	Diabetes			m.	Other, if yes, explain		

MENTAL HEALTH:

6. In the past five *(5)* years, have any members of your family, excluding service member, been treated for, or had any problems related to any of the following? *(You will have an opportunity to discuss all "YES" answers with a screener.)*

		YES	NO			YES	NO
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem	☐	☐	d.	Alcohol and drug use or abuse		
				e.	Emotional problems		
b.	Depression			f.	Behavioral problems/acting out behavior		
c.	Suicidal thoughts/ideas, gestures, attempts	☐	☐	g.	Received therapy *(marital, family, individual or group counseling)*	☐	☐

7. Have any members of your family, excluding service member, been in any of the following? Inpatient Psychiatric Facility, Residential Treatment Center, Group Homes, Day Treatment Centers, Drug and Alcohol Treatment Rehabilitation Center. If Yes, please explain: YES ☐ NO ☐

EDUCATION

8. Do any of your children now have, or have they ever had, any of the following?

		YES	NO			YES	NO
a.	Slow development *(infants and preschoolers)*			d.	Counseling services for school-related problems	☐	☐
b.	Learning problems *(school)*						
c.	Special services *(i.e., OT, PT, Speech, etc.)* for special education	☐	☐	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? YES ☐ NO ☐

According to AR 608-75, Exceptional Family Member Program, soldiers will provide accurate information as required when requested to do so by Army officials. Knowingly providing false information in this regard may be the basis for disciplinary or administrative action. For soldiers, refusal to provide information may preclude successful processing of an application for family travel or command sponsorship.

Commanders will take appropriate action against soldiers who knowingly provide false information, or who knowingly fail or refuse to enroll family members that meet the criteria for enrollment. *(A false official statement is a violation of Article 107, Uniform Code of Military Justice (UCMJ).)* These actions will include, at a minimum, a general officer letter of reprimand.

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 COMPLETING THIS FORM	DATE *(YYYYMMDD)*
PRINTED NAME OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	SIGNATURE OF PHYSICIAN OR MEDICAL PRACTITIONER IF UNDER THE SUPERVISION OF A PHYSICIAN	DATE *(YYYYMMDD)*

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement
Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).
Purpose: To identify medical, dental or educational conditions for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.
Routine uses: This form is completed by a military/civilian physician, nurse practioner, physician assistant, or independent duty corpsman. The medical treatment facility (MTF) Suitability Screening Coordinator will place the completed original form in the service or family member's MTF medical record and retain a copy for audit.
Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2A for implementing guidance. ***Complete one form for each service and family member screened.***

SERVICE MEMBER NAME	GRADE / RATE	SSN
FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	SSN

NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):	TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)

PART I

Medical Screening. Completed by the medical provider to identify special needs and determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. Attach the completed Report of Medical History (DD 2807-1) to this form.

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. Physical examinations (aviation, submarine, radiation, asbestos, etc.) current and documented?
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4. Immunizations are up-to-date and meet destination country requirements?
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? *(document on DD 2807-1)*
			11. For all service members, annual preventive health assessment (PHA) current and documented?
			12. For servicewomen:
			a. Annual health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)?
			c. If pregnant? (EDC:)
			13. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			14. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			15. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)*
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, adjustment/personality disorder, ADD/ADHD, anxiety, psychosis)
			g. Recurrent or frequent medications not on the standard formulary *(list on DD 2807-1)*
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			16. For service/family members requiring medication in excess of 90 days: (if not applicable, check block and skip to #18)
			a. Is the patient in the maintenance phase of treatment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Is the medical staff at the gaining MTF/operational platform capable of managing the medication manipulation(s) if the underlying condition exacerbates?
			d. Has the service/family member registered with the TRICARE Mail Order Pharmacy program?

Yes	No	N/A	ITEM
			17. For service/family members with underlying medical conditions: *(if not applicable, check block and skip to #18)*
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Can the gaining MTF/operational platform provide the current required medical support?
			d. Can the gaining MTF/operational platform provide required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated?
			e. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? *(document on DD 2807-1)*
			f. If required, were potential environmental concerns and possible health effects communicated to each service and family member? *(document on appropriate SF 600)*
			18. For infants and toddlers (birth through 2 years, inclusive) with a disability, is the child receiving or eligible to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			19. For preschool and school children (ages 3 through 21, inclusive) with a disability, is the child receiving or eligible to receive special education and related services as evidenced by an Individualized Education Program (IEP) and DD 2792, Addendum B?
			20. Specify other concerns:

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, QUERY THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY OR OPERATIONAL LOCATION CONCERNING LOCAL CAPABILITIES TO PROVIDE REQUIRED SUPPORT. *(Attach Reply)*

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(completed by an MTF medical screener only)*

MTF Medical Screener (Signature) _____ Date _____

Printed Name, Rank or Grade _____

MTF or Duty Station _____

Telephone Number (include area/country code) _____

DSN Number _____

Telefax Number (include area/country code) _____

E-mail Address _____

Civilian Medical Screener (Signature) _____ Date _____

Printed Name _____

Address _____

City, State, and ZIP Code _____

Telephone Number (include area/country code) _____

Telefax Number (include area/country code) _____

E-mail Address _____

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN

Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility.

Yes	No	N/A	ITEM
			1. All current dental records (military and civilian) reviewed?
			2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
			3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
			4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
			5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
			6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
			7. Specify other concerns:

8. Specify Dental Class: *(required for service members)* _____

Dental Classifications: (Per DoDI 6025.19)

Normally considered worldwide deployable:
Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.
Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:
Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.
Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, FORWARD A SUITABILITY INQUIRY TO THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY, OR OPERATIONAL LOCATION TO DETERMINE IF THE REQUIRED DENTAL SUPPORT IS AVAILABLE. *(attach reply)*

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(completed by an MTF designated military dental screener only)*

MTF Medical Screener (Signature) _____ Date _____	Civilian Medical Screener (Signature) _____ Date _____
Printed Name, Rank or Grade	Printed Name
DTF or Duty Station	Address
Telephone Number (include area/country code)	City, State, and ZIP Code
DSN Number	Telephone Number (include area/country code)
Telefax Number (include area/country code)	Telefax Number (include area/country code)
E-mail Address	E-mail Address

MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14C authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for successful completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2A for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original form in the service or family member's MTF medical record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charQe of a chanQe in status (includinq preqnancvl. *Complete one form for each service and familv member screened.*

SERVICE MEMBER NAME	**GRADE / RATE** **ISSN**
CURRENT UNIT	**TELEPHONE NUMBER**
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	**TYPE DUTY CLASSIFICATION CODE (Navy enlisted only)**
FAMILY MEMBER NAME	**FAMILY MEMBER PREFIX**

	SSC Review		
FOR SERVICE MEMBERS:	**Yes**	**No**	**N/A**
D Legible copy of orders. (For operational assignments, orders should indicate the platform to which assiqned and a description of the duty assiqnment.)			
D Each family member name, family member prefix, social security number, address and telephone number, if other than the service member's.			
Military health record to include:			
D Routine physical, aviation, submarine, radiation, asbestos, or other type of examination or screeninq current and documented.			
D Annual Preventive Health Assessment (PHA) current and documented.			
D Current medical history (DD 2807-1).			
I I Hearinq (audioqram).			
D Vision examination.			
test			
st.			
Cell trait test.			
D Negative HIV results current to I year of transfer. *Date Drawn:* *Roster Number:*			
D Blood type.			
D DNA testinq.			
D Required immunizations (assignment specific).			
D Military dental records			
D Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
D Other:			

	SSC Review		
	Yes	No	N/A
FOR WOMEN:			
D Annual health assessment current and documented.			
D Mammogram current and documented.			
D Pregnancy screen (verbal inquiry).			
FOR FAMILY MEMBERS:			
D Military health record			
D Military dental record			
D Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
FOR INFANTS AND TODDLERS (birth through 2 years, inclusive) receiving or eligible to receive Early Intervention Services: D Copy of the current Individualized Family Service Plan (IFSP) and, if available, developmental assessments or evaluations.			
FOR EACH CHILD ENROLLED IN PRESCHOOL OR SCHOOL (ages 3 through 21, inclusive): D Coov of DD 2792-1 completed by the school.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (ages 3 through 21, inclusive) receiving or eligible to receive Special Education to include related services: D Copy of the current Individualized Education Plan (IEP) and, if available, educational assessments or evaluations			
FOR EACH FAMILY MEMBER ENROLLED IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP): D Copy of the enrollment application and any EFMP correspondence.			

FOR SSC USE ONLY

Date suitability screening conducted:

If suitability determination with gaining MTF is required:

Date and time group of inquiry: Originator:

Date and time group of reply: Originator:

Other information:

Suitability Screening Coordinator (signature, printed name, and date):

REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENT

SUPPORTING DOCUMENTATI0N OPNAVINST 1300.14C

MEMBER'S NAME:		SSN:	DATE:
PRESENT SHIP/STATION:	UIC:	OVERSEAS LOCATION:	UIC:

NUMBER OF DEPENDENTS:

PART I: COMMAND REVIEW - The purpose of the Command Review is to determine, via record review and personal interview, member and spouse/family member(s)' suitability for overseas duty/life in the assigned overseas location. (To be completed by Commanding Officer of transferring command.) Refer to MILPERSMAN Articles 1300-302 and 1300-304. Any questions checked "YES" (with the exception of questions 11 and 15), disqualifies member for overseas assignment. If command still recommends member should be considered for overseas assignment, submit waiver request per MILPERSMAN 1300-302.

1. ☐ YES ☐ NO Has the member or any spouse/family member(s) previously been reassigned, prior to normal tour completion, due to their unsuitability?

2. ☐ YES ☐ NO (For Enlisted Personnel) Does the member refuse to obligate sufficient service (OBLISERV) to complete the prescribed tour? If "NO", ensure member reenlists (NAVPERS 1070/621) to incur sufficient OBLISERV, per MILPERSMAN 1306-106. Page 13 entries for OBLISERV are prohibited. **(OBLISERVE MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS).** For SRB issues, see the current NAVADMIN.

3. ☐ YES ☐ NO (E5 and above) Does the member, spouse, or family member(s) have serious problems of indebtedness, credit loss or other financial problems which have not been reconciled with the creditor(s) or interested parties (i.e., bankruptcy)?

   ☐ YES ☐ NO a. (E4 and below) Member must complete debt-to-income (DTI) ratio screening IAW OPNAVINST 1740.5A, (Command Financial Specialist Training Manual 15608). Is DTI ratio 30% or greater?

4. ☐ YES ☐ NO Has the member been convicted for any civilian offense(s) (civil or criminal) within the last 24 months or had any involvement in any ongoing civil or criminal action?

5. ☐ YES ☐ NO Has spouse or any family member(s) been convicted for any civilian offense(s) (civil or criminal) within the last 24 months or have any involvement in any ongoing civil or criminal action?

6. ☐ YES ☐ NO Does the member have a record of any involvement with illegal drugs or alcohol within the past 24 months? For alcohol related cases, if member has completed an education or early intervention program, they are suitable for overseas assignment and this question can be answered "NO".

7. ☐ YES ☐ NO Does the spouse/family member(s) have a record of any involvement with illegal drugs or alcohol within the past 24 months?

8. ☐ YES ☐ NO Is the member or spouse/family member(s) involved in an open FAP (Family Advocacy Program) case that is still under investigation or for which treatment is still ongoing? (Any case/cases that has/have been adjudicated "Closed," shall not be considered disqualifying).

   ☐ YES ☐ NO a. In any case, does the local FAP representative have any reason to NOT favorably endorse member with family members for overseas duty?

9. ☐ YES ☐ NO Was the member's spouse previously a member of the armed forces and the characterization of separation other than "Honorable"? Explain in the remarks section.

MEMBER'S NAME:	SSN:	DATE:

10. ☐ YES ☐ NO Are there any concerns whether member/spouse has legal custody of all accompanying minor family members?

11. ☐ YES ☐ NO Are any of the member's family members covered in a custody agreement? If "NO," go to question 12.

☐ YES ☐ NO a. Does agreement prevent removal of family members from CONUS without prior court approval or agreement between the interested parties? If "NO," go to question 12.

☐ YES ☐ NO b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (Please note: Navy policy does not require a separate agreement if not required by state law.)

12. ☐ YES ☐ NO Single parents/military couples with family members. Are there any reasons why family member care requirements can not be met in accordance with OPNAVINST 1740.4A?

NOTE: While the unique situation of single parents with family members is not in itself disqualifying, this fact should be pointed out upon submission of message certification of screening to NAVPERSCOM (PERS-40)/(EPMAC.)

13. ☐ YES ☐ NO (For Enlisted Personel) Is member an initial accession enroute to their first duty station with pre-service moral waiver(s) (drug, alcohol, or criminal)?

14. ☐ YES ☐ NO Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJP's in the last two years?

15. ☐ YES ☐ NO Has member and adult dependents received "Level I" Antiterrorism Force Protection (Level III for O-5/O-6 Commanding Officer Awareness Training), prior to transfer, and recorded on Page 13? (Contact your local Family Service Center if training is not available at your command)

FOR PERSONNEL E-3 AND BELOW: Ensure the member has been counseled that personnel in these paygrades, having family members, will not be assigned accompanied overseas duty. Members can be assigned unaccompanied based on readiness needs. (NOTE: Single E-3 and below who acquire (a) family member(s) en route and bring them without dependent entry approval/command sponsorship, will most probably return them at personal expense and serve the complete area tour unaccompanied.)

I have been counseled on the above: ☐ YES ☐ NO

MEMBER'S SIGNATURE:	DATE:

REMARKS:

I, _____, am aware that the failure to divulge disqualifying information or amplifying information (medical, dental, personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.

MEMBER (NAME, RANK/RATE):	MEMBER (SIGNATURE):	DATE:
INTERVIEWER (NAME, RANK/RATE, COMMAND TITLE):	INTERVIEWER (SIGNATURE):	DATE:

MEMBER'S NAME:	SSN:	DATE:

PART II: RECOMMENDATION OF COMMANDING OFFICER OR OFFICER IN CHARGE OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening and on the capabilities of the Medical/Dental Treatment Facility in the area of assignment to which ordered, the following recommendation is forwarded:

1. Medical, dental and educational screening was conducted per BUMEDINST 1300.2.

2. Recommendation is based on a review of NAVMED 1300/1, Part I and II. One form has been completed for each service and family member screened.

3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty or operational location or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental or educational capabilities are available.

4. Family member screening is not required if an unaccompanied tour of 24 months or less (Exception: Screening is required for Diego Garcia/Souda Bay, Crete).

5. Do not forward sensitive medical or personal information with this form.

The following recommendation(s) are made based on a review of each NAVMED 1300/1, Part I and II, and if required, the response from the gaining MTF/DTF or senior medical department representative of the gaining command:

☐ YES ☐ NO SERVICE MEMBER IS SUITABLE FOR THIS ASSIGNMENT.

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT:

☐ YES ☐ NO (NAME)	☐ YES ☐ NO (NAME)
☐ YES ☐ NO (NAME)	☐ YES ☐ NO (NAME)
☐ YES ☐ NO (NAME)	☐ YES ☐ NO (NAME)

The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR ESM DETERMINATION):

NAME(s):

NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	DATE:	SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:

MEMBER'S NAME:	SSN:	DATE:
PART III: CMC/COB/SEA ENDORSEMENT		
On the basis of all available information, I endorse ☐/ I do not endorse ☐ the member's orders for the overseas assignment.		
CMC/COB/SEA (NAME, RANK)	CMC/COB/SEA (SIGNATURE)	DATE
PART IV: COMMANDING OFFICER'S ENDORSEMENT		
On the basis of all available information, I endorse ☐/ I do not endorse ☐ the member's orders for the overseas assignment.		
Commanding Officer (Name, Rank)	Commanding Officer (Signature)	Date

REMARKS:

PRIVACY STATEMENT: THE AUTHORITY TO REQUEST THIS INFORMATION IS CONTAINED IN 5 USC 301 DEPARTMENTAL REGULATIONS. THE INFORMATION WILL BE USED TO ASSIST OFFICIALS AND EMPLOYEES OF THE DEPARTMENT OF THE NAVY IN DETERMINING YOUR FUTURE DUTY ASSIGNMENT.

COMPLETION OF THE FORM IS MANDATORY EXCEPT FOR DUTY AND HOME PHONE NUMBERS OR FAILURE TO PROVIDE REQUIRED INFORMATION, MAY RESULT IN DELAY IN RESPONSE TO OR DISAPPROVAL OF YOUR REQUEST.

EXCEPTIONAL FAMILY MEMBER PROGRAM-MEDICAL (EFMP-M) INFORMATION FORM

Welcome to the Exceptional Family Member Program-Medical (EFMP-M). EFMP-M ensures medical and special education information is considered by the appropriate review authorities prior to authorizing government-sponsored travel for family members. EFMP-M implements the Family Member Relocation Clearance (FMRC) process requirements for EFMP-enrolled sponsors at each Permanent Change of Station (PCS), and for all sponsors planning to take family members overseas. EFMP-M supports the Exceptional Family Member Program (EFMP) by determining when EFMP enrollment criteria are met, and by providing necessary support information when an EFMP Reassignment is requested.

A vital part of the EFMP-M process is to support mobile families through relocation, for families of both active duty and DoD civilian sponsors. EFMP-M gathers information about family members' health and special education histories from existing data sources and from service providers. EFMP-M determines the availability of medical and special education services in the projected location, based on this review of known family member conditions, to avoid relocating family members to locations that cannot meet their needs. Where special needs are identified, as defined by DoDI 1315.19, **Authorizing Special Needs Family Members Travel Overseas at Government Expense,** Enclosure 4, the Special Needs Coordinator is required to request an assignment limitation code, "Q", for active duty sponsors. This "Q-code" provides a level of protection for families with special needs, to ensure deployments and reassignments are considered in conjunction with the family member's therapeutic program. Families of active duty members may not travel under command sponsorship to locations that cannot ensure the protection of their federal and DoD benefits and entitlements. Assignment coordination support is offered to all DoD-affiliated families, regardless of sponsor's service category or the presence of a documented special need. However, decisions regarding travel remain with the sponsor for DoD civilians and others who are not active duty.

For active duty members, EFMP Reassignments and deferments are two of the options that may be considered when services are not available at a duty station. However, both retention at the current base and assignment to another base are dependent upon vacancies and manning requirements of the Air Force. The EFMP-M process is not a "base of choice" service for the sponsor. Active duty members must still serve overseas when ordered, regardless of the presence of family members with special needs. Members who are selected for overseas assignment to a location where medical or special education services are not available for family members may elect the option of an unaccompanied short tour. AF Personnel Center (AFPC) retains the final authority on all assignment actions.

It is important you know the intended uses of the information you provide and the limitations on confidentiality. Military health care records and administrative records maintained by the military treatment facility, including our separately maintained Special Needs Assignment Coordination files and logs, are the property of the U.S. Government. The same controls apply to these records as other government documents. Information disclosed by you to the Special Needs Coordinator or Family Member Relocation Clearance Coordinator is considered sensitive information and is treated as such. This means access to this information is allowed for the purpose intended, to coordinate care through relocation, and as required by law, regulation, judicial proceedings, health care facility accreditation or inspection, or when authorized by the identified patient or parent of a minor.

If EFMP enrollment is initiated, a folder is created to maintain an ongoing record of services and contacts throughout the length of the sponsor's career, or period of EFMP enrollment. If no EFMP enrollment is warranted, logs and forms used to coordinate relocation are maintained for 2 years after processing for process accountability. Requests for information from sources outside the Department of Defense will not be honored unless you first give written permission for the release of information.

Here are some examples where limits on confidentiality may apply:

1. Release of information may be required by regulation. We will do everything we can to ensure individuals with the right to know find out only what they need to know. If you are Active Duty, your commander or higher chain of command may have the need to know some of the information you disclose to us.

2. If you tell us of a situation involving a violation of military regulations, the Uniformed Code of Military Justice (UCMJ), or civil law, we may be required to divulge that information to the chain of command and/or other authorities.

3. If you voice a threat to harm yourself or someone else, or if family maltreatment is alleged or suspected, we may share information as needed to ensure safety.

4. Where there is a need to know, other DoD health care professionals associated with your family's care may have access to some EFMP-M process information in order to coordinate health care delivery.

5. Exceptional Family Member Program-Family Support (EFMP-FS) may be informed of the presence of Q-code status without accompanying medical information, in order for EFMP-FS to assist families with potential support services that may be available.

6. As part of EFMP case reviews, information may be shared with medical staff and EPMP-FS Coordinators in order to assist with family service plan development.

7. Qualified individuals authorized to conduct officially sanctioned research, administrative and/or legal reviews may review EFMP-M records to evaluate services or to conduct other research toward improving processes or services. Research findings or administrative/process improvement reviews NEVER include individual names or other identifying information.

8. The work of EFMP-M technicians and student professionals is reviewed after each client contact to ensure quality services are provided and standards of care are met.

In accordance with the above guidelines, we will strive to safeguard information obtained from you and ensure only authorized sources with a valid need to know have access.

Please ask the EFMP-M staff any questions you have on EFMP-M or about the use of information obtained in the EFMP-M processes.

EXCEPTIONAL FAMILY MEMBER PROGRAM-MEDICAL (EFMP-M) INFORMATION FORM (Cont'd)

Statement of Understanding

I have read the EFMP-M Information Form and understand that information about family members' health and special education needs will be safeguarded, acknowledging the limitations of confidentiality mentioned above and IAW the Privacy Act of 1974 (DD Form 2005).

Sponsor Signature:

_____ Date:

Adult Family Member Signature, if briefed on EFMP-M process:

_____ Date:

Adult Family Member Signature, if briefed on EFMP-M process:

_____ Date:

I have reviewed the EFMP-M process and purposes to the above-identified client(s) to ensure understanding and have discussed the limits of confidentiality.

EFMP-M Staff member Signature:

_____ Date:

REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATION CLEARANCE FOR TRAVEL

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical and educational needs of family members. This information will enable: (1) Military assignment personnel to authorize family member travel at government expense based on availability of needed services at the gaining installation; and (2) Civilian personnel offices to determine the availability of medical/educational services to meet the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for family travel/command sponsorship. 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.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority - Public 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.
This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____ (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special 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.

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 coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.

Expiration Date: The authorization shall continue until you no longer meet the criteria to qualify as a dependent (active duty family members) or no longer desire to travel overseas at government expense (civilian employee family members), or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

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 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 my protected information on the basis of this authorization.

b. If I authorize my 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 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 to the named individual/organization indicated.

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.

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

SPONSOR *(Last, First MI)*: SSN:

SECTION IV - FAMILY MEMBERS REQUESTING COMMAND SPONSORSHIP TO TRAVEL *(Continued)*

FAMILY MEMBERS ACCOMPANYING SPONSOR							CHECK ALL CONDITIONS THAT APPLY					
FAMILY MEMBER'S NAME *(Last, First, Middle Initial)*	RELATIONSHIP	AGE	GRADE IN SCHOOL	LOCATION OF MEDICAL RECORDS	COPIES PROVIDED	MONTH / YEAR OF TRAVEL	MEDICAL / EMOTIONAL / BEHAVIORAL	DENTAL	EDUCA- TIONAL	EI or RS SERVICES	MODIFIED HOUSING	NONE
					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐
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					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐
					☐	____/______	☐	☐	☐	☐	☐	☐

SECTION V - CERTIFICATION OF APPLICANT

I certify that I have read and understand the previous instructions and that those entries made by me are true, complete, and correct to the best of my knowledge and belief.

Initials

____ I understand that I must inform the Special Needs Coordinator (SNC) of any changes to health/educational conditions prior to travel of family member listed in Section IV.

____ I understand that insufficient and/or inaccurate information may affect family member travel.

____ I understand that a knowing and willful false statement on this form can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ, Article 92 UCMJ).

____ I have disclosed to the SNC all known medical or special educational conditions for all family members planning travel.

____ I understand that failure to report these conditions may result in disciplinary action as a false official statement. Attempts to obtain a benefit, to include medical care or government sponsored travel by withholding information regarding my family member care histories may be reported to my commander.

____ I understand that choosing to take family members who are not recommended for government sponsored travel, at my own expense, may result in disciplinary action, significant personal expense, and may place family member in a location where necessary care or services are not available to them.

____ I understand I may request EFMP Reassignment via vMPF if one or more of my family members are not recommend for travel, or elect OCONUS travel unaccompanied.

DATE (YYYYMMDD)	PRINTED NAME AND GRADE OF SPONSOR	SIGNATURE

SPONSOR NAME *(Last, First MI):* **SSN:**

SECTION VI - MEDICAL PROVIDER EVALUATION

Inquiry	YES	NO
A. All Family Members' Medical Records Reviewed? (If NO, comments required below).	☐	☐
B. All Family Members in Section IV Interviewed? (If NO, comments required below).	☐	☐
C. Special Medical Conditions Identified? (If YES, complete DD Form 2792).	☐	☐
D. All Family Members' AF Form 1466D reviewed? (If NO, comments required below).	☐	☐
E. Any unresolved dental care needs/problems identified on the AF Form 1466D?	☐	☐

I have confirmed the following presence or absence of specialty consultations and of pharmacy data indicating further review or potential special needs may be warranted. Comments required.

COMMENTS:

I have seen and interviewed all family members requesting travel and determined that FDI is ☐ is not ☐ required.

___ Number of DD Form 2792s attached. ___ Number of DD Form 2792-1s attached. ___ Number of AF Form 1466Ds attached

DATE (YYYYMMDD)	TYPE/PRINT NAME AND GRADE OF MEDICAL PROVIDER	SIGNATURE

SECTION VII - SPECIAL NEEDS COORDINATOR ENDORSEMENT

INQUIRY	YES	NO
A. History of Family Advocacy Involvement? *(If YES, complete DD Form 2792, Addendum 2)*	☐	☐
B. History of Mental Health Needs? *(If YES, complete DD Form 2792, Addendum 2)*	☐	☐
C. Has artificial openings / requires prosthetics? *(If YES, complete DD Form 2792. Ensure Part B, Section 8, is completed.)*	☐	☐
D. Requires Modified Housing? *(If YES, complete DD Form 2792. Ensure Part B, Section 9, is completed.)*	☐	☐
E. Requires Adaptive Equipment / Special Medical Equipment? *(If YES, complete DD Form 2792. Ensure Part B, Section 10, is completed.)*	☐	☐
F. Has Individualized Education Plan for Special Education? *(If YES, complete DD Form 2792-1)*	☐	☐
G. Has Individualized Family Service Plan or high probability for development delay. *(If YES, complete DD Form 2792-1)*	☐	☐

COMMENTS REQUIRED

DATE (YYYYMMDD)	TYPE/PRINT NAME AND GRADE OF SPECIAL NEEDS COORDINATOR	SIGNATURE

SECTION VIII - CERTIFICATION BY LOSING BASE MDG / SGH

Any YES response in Sections VI C or VII require forwarding this AF FORM 1466 to the gaining base for review via Facility Determination Inquiry.

Comments Required:

I have reviewed all information collected and find it sufficient for medical decision making.

Comments reviewed and determined that FDI is ☐ is not ☐ required.

___ Number of DD Form 2792s attached.

___ Number of AF Form 1466Ds attached.

___ Number of DD Form 2792-1s attached.

DATE(YYYYMMDD)	NAME & GRADE OF LOSING SGH	SIGNATURE

SPONSOR NAME *(Last, First MI):* **SSN:**

SECTION IX - FACILITY DETERMINATION INQUIRY, DISPOSITION BY MDG / SGH

Family member(s) travel is recommended.

Family member(s) require(s) FDI. **Note: Orders may not be issued until FDI completed by Gaining SGH.**

DATE (YYYYMMDD)	TYPE / PRINT NAME AND GRADE OF LOSING BASE SGH	SIGNATURE

Name of Losing Installation *(PRINT LEGIBLY)*

Family member(s) travel is recommended.

Family member(s) travel is not recommended.

ADDITIONAL COMMMENTS	Check all that apply:				
Family Member Name	Care available in MTF	Care available in local area	Care/Services not available	Recommend Care Coordination through PCS	Other

DATE (YYYYMMDD)	TYPE / PRINT NAME AND GRADE OF GAINING BASE SGH	SIGNATURE

Name of Gaining Installation *(PRINT LEGIBLY)*

DENTAL HEALTH SUMMARY *(To be completed by dental provider)*
(This Form is subject to the Privacy Act of 1974 – USE BLANKET PAS – DD FORM 2005))

PRINCIPAL PURPOSE: An assessment by a dentist is needed to determine your dental health as part of the family member relocation clearance for travel.

If you are enrolled in the TRICARE Dental Plan, your **civilian dentist completes this form.**

If you are not enrolled in the TRICARE Dental Plan, your **military dental treatment facility** completes this form.

1a. PATIENT NAME (Last, First, Middle Initial)	**b. SPONSOR SSN**	**c. FAMILY MEMBER PREFIX**

2. DENTAL EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is a family member of an active duty member of the United States Armed Forces. This family member needs your assessment of his/her dental health for a pending duty assignment. Please mark (X) **the block** that best describes the condition of the family member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine the oral fitness for prolonged assignment without ready access to dental care of the family member, it is not intended to address the member's comprehensive dental needs.

☐ (1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

☐ (2) Patient has some oral conditions, but you do not expect these conditions to result in dental emergencies within 12 months if not treated (i.e. requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).

☐ (3) Patient has oral conditions that you do expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: *(X the applicable block or specify in the space provided)*

- ☐ (a) Infections: Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
- ☐ (b) Caries/Restorations: Dental caries or fractures with moderate or advanced extension into dentin; baby bottle tooth decay/early childhood caries; defective restorations or temporary restorations that patients cannot maintain for 12 months.
- ☐ (c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communications, or acceptable esthetics.
- ☐ (d) Periodontal Conditions: Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival conditions, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
- ☐ (e) Oral Surgery: Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
- ☐ (f) Other: Temporamandibular disorders or myofascial pain dysfunction requiring active treatment.

☐ (4) Patient is undergoing active orthodontics treatment

3. If you selected Block (3) or (4) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) and recommended treatment (s) below:

4. Were x-rays consulted?	☐	YES	☐	NO	If yes, date x-ray was taken (YYYYMMDD)

5a. **DENTAL PROVIDER NAME**	b. **SIGNATURE**	c. **DATE (YYYYMMDD)**

AIR FORCE SPECIAL NEEDS SCREENER

(Completed by all Sponsors with Family Members)

AUTHORITY: 10 U.S.C. 55. 10 U.S.C. 8013 and E.O. 9397 (SSN) as amended.

PURPOSE(S): Used to document, plan, and coordinate the health care of family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data.

ROUTINE USE: Used to accumulate information for determining family member special needs.

DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of family member's suitability for relocation at government expense or delay issuance of PCS orders.

TO: SPECIAL NEEDS COORDINATOR AND AIR FORCE PERSONNEL CENTER (AFPC)

FROM: Air Force Family Member Special Needs Identification Screener

The Air Force makes an effort to ensure specialized medical and educational services are available for all military family members. In order to help us do this, we need to know if any special medical and/or educational needs exist for your family members. You are required to complete this form as part of your relocation processing, if you have family members, whether they are living with you or not.

SPONSOR'S INFORMATION

Sponsor's Name *(Last, First, MI)* _____

Rank _____

Social Security Number *(SSN)* _____

Current Unit and Duty Station _____

Duty Telephone Number _____

Home Telephone Number _____

Projected Installation For Relocation _____

Projected Departure Date _____

SPONSOR'S FAMILY INFORMATION

Please read and answer all questions. Indicate (X) the appropriate box. **Thank you.**

1. Are your currently enrolled in any Service's Exceptional Family Member Program (EFMP)? Yes ☐ No ☐

If yes, stop here.

2. Do any of your children receive Special Education Services? Yes ☐ No ☐

3. Do any of your children receive Early Intervention Services? Yes ☐ No ☐

4. Do any of your children receive speech therapy, occupational therapy, physical therapy, or counseling services? Yes ☐ No ☐

5. Has any dependent member of your family been hospitalized for the same condition more than once? Yes ☐ No ☐

6. Has any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than six times in the last year? Yes ☐ No ☐

7. Do any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist (such as cardiology, internist, psychology, neurology, counseling, etc.)? Yes ☐ No ☐

8. Do any of your dependent family members have reactive airway disease or asthma? Yes ☐ No ☐

If YES to any questions numbered 2 - 8, please contact the Exceptional Family Member Program (EFMP-M) Office at the Military Treatment Facility for assistance prior to pursuing any further relocation actions.

I certify that this information is complete and accurate to the best of my knowledge. I understand that insufficient and/or inaccurate information may affect family member travel at government expense. I understand that making a knowing and willful false official statement can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

Sponsor's Signature _____ Date _____

AF FORM 4380, 20110819