AF Form 4380, *AIR FORCE SPECIAL NEEDS SCREENER*

This form is required to be completed by all HPSP students and FAP and deferred applicants.

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. This form will help to ensure that, if necessary, your family receives continuity of any specialized care they require if you are selected for an active duty training location.

This form must be uploaded into MODS as part of your application package. The form does not affect the scoring of your application package and will only be coordinated with the Air Force Programs for Families with Special Needs if you are selected for an active duty program and if you answer yes to any questions.

If necessary, the Air Force Programs for Families with Special Needs will contact you for additional information and will assist coordinating relocations for families who have specialized medical or educational needs.

Please ensure that you sign and date the form.

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 _____

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