DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY MEDICAL DEPARTMENT ACTIVITY (ALASKA)
FORT WAINWRIGHT, ALASKA 99703-7400

http://www.alaska.amedd.army.mil

REPLY TO
ATTENTION OF

Completion of Command Sponsorship, Overseas screening or Extensions for Family Members *NOT* located in Alaska

1. Complete "Contact Information for Family Members for Screening" page (p.2).
2. DA 5888 (p.3) Part A 1 through 7 must be completed by Soldier. Either the Soldiers **Unit S1 or Military Personnel Division (MPD) will sign part 8. Authentication section**.
3. Bring forms to floor of Bassett Army Community Hospital, located with the Primary Care Departments and check in at the front receptionists or email to usarmy.wainwright.medcom-bsac.mbx.meddac-ak-efmp@mail.mil

Completion of Command Sponsorship, Overseas screening or Extensions for Family members located *IN* Alaska.

1. Ensure Family Member is enrolled in DEERS, and Tricare.
2. A physical exam is required for all dependents requesting EFMP screening. For Dependents age 6 and older physical exam must be completed within the last year. For Ages 5 and under, physical exam must be completed within 6 months of the screening date. **If your family member has not had a physical exam please call 907-361-4000 to schedule the age appropriate physical.**
3. DA 5888 (p.3) Part A 1 through 7 must be completed by Soldier. Either the soldiers **Unit S1 or Military Personnel Division (MPD) will sign part 8, Authentication section**.
4. Complete DA 7246 (included P.4&5) for dependent family members.
5. If on orders to Europe, the SERVICE MEMBER must sign the Europe memo provided (p.6).
6. Obtain a COMPLETED and CURRENT DEERS 1172 (Welcome center, ID Card office), with family member's correct and current address. Please note, if family does not permanently reside in Alaska then the EFMP Screening cannot be performed in Alaska.
7. Once steps 1-4 have been completed please bring all forms into the EFMP office located on the first floor of Bassett Army Community Hospital, located with the Primary Care Departments and check in at the front receptionists. At that time you will be scheduled (below) for an EFMP screening for your Command Sponsorship, Overseas screening or Extension request.

- Please remember that ALL family members must be present at the Screening appointment.
- If arriving more than 10 minutes late to your scheduled appointment, you may need to be rescheduled.

_____'s (_____) EFMP Screening appointment is on

_____ at _____.

Hours: M,T,W, F 0800-1200, 1300-1600
Thurs 1300-1600

Exceptional Family Member Program
Bassett Army Community Hospital
907-361-5959/5825 fax: 907-361-4835

Contact Information for Family Members for Screening

This form should be turned in to your local EFMP Medical Office for further processing.

PLEASE FILL OUT FORM COMPLETELY
PLEASE PRINT *CLEARLY*

Sponsor's name:_____

Sponsor's SS#: _____-_____-_____

Sponsor's phone number(s): _____

Current Location:_____

Family member name(s) and Dates of Birth:

_____

_____

_____

_____

Family Member's Email address:

_____

Phone number(s) where your family can be contacted immediately:

Home:_____

Cell: _____

Work: _____

Family Member's Mailing Address where they can be reached:

_____

_____

_____

DOUBLE CHECK THE ABOVE INFORMATION FOR ACCURACY.
Please be certain to tell your family someone from EFMP will be contacting them shortly!

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.

SOLDIER completes BLOCK 1-7 ONLY

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

UNIT S-1 completes BLOCK 8 ONLY

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

EFMP OFFICE completes BLOCKS 9-11 ONLY

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
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

10. 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)*	

11. 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 assignment process.

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.

Dependent or Parent completes ALL blocks on this page

SERVICE MEMBER'S NAME/RANK		DATE *(YYYYMMDD)*
BRANCH	UNIT	DUTY PHONE
PROJECTED PCS ASSIGNMENT	DSN	HOME PHONE
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

1 FORM FOR ALL FAMILY MEMBERS

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 ☐

Dependent or Parent completes ALL Blocks on this page 1 FORM FOR ALL FAMILY MEMBERS PLACE NAME OF FAMILY MEMBER(s) NAME in the block you answered YES

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.

Signature of PARENT OR Dependent

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)*

DEPARTMENT OF THE ARMY
UNITED STATES ARMY REGIONAL HEALTH COMMAND EUROPE
UNIT 29421
APO AE 09136-9421

MCEU-CLE

29 November 2017

MEMORANDUM FOR Regional Health Command Europe, Exceptional Family Member Program (EFMP), APO AE 09042

SUBJECT: Acknowledgement of Documents submitted for Family travel by Service Member (SM)

1. The EFMP Office completing the documents is the originating OCONUS Screening (OSS) office, RHCE EFMP is the gaining EFMP office. All information in both the OSS and Family Member medical records will be used in the family travel review process to make recommendations on the availability of care in assignment locations. SM and Family is responsible for reviewing the completeness and accuracy of the information and recommendations in the Family members file._____(SM Initials).

2. If there are any changes to medical or educational information it is the SM responsibility to inform originating OSS office._____(SM Initials).

3. If Family travel is approved, medical care may be provided by host nation providers. Local provider(s) may revise the beneficiary's treatment plan, so the current treatment may not be continued in the overseas environment. Additionally, there may be some cultural and language barriers associated with receiving care on the local economy that could impact the sponsor/patient's expectation of care._____(SM Initials).

4. The EFMP Office that completes the OSS holds the responsibility of reviewing all the forms with the Family/SM, for providing guidance in reference to a reconsideration, and/or updating medical information._____ (SM Initials)

5. If a SM receives a Family travel denial message they should contact their personnel office and branch manager for assignment options. Medical information questions will be referred to, the point of contact in the office that completed the OSS._____(SM Initials)

6. I have read and understand these instructions and the instructions for DD Form 2792. In accordance with AR 608-75, Soldiers who knowingly and willfully disregard or provide false information might be subject to Uniform Code of Military Justice (UCMJ, Art. 92 and Art 107).

_____	_____	_____
Service Member Printed Name	Signature	Date

7. Point of contact for this memorandum is the EFMP Office that completed the OSS.

Regional Health Command Europe
EFMP Family Travel Office