



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 <u>NOT</u> 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 <u>IN</u> 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 <u>CLEARLY</u>

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!

DATA REQUIRED BY THE PRIVACY ACT OF 1974 AUTHORITY: The 10, USC Section 3013. PRINCIPAL PURPOSE: To validate family member deployment screening, and to provide gaining command with data to assist marking 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 scion against the solder. 1 NAME OF SOLDIER (Last, first, MI) 2. SOCIAL SECURITY NUMBER Sa. RANK 3b. MOS/E 4a. HOME ADDRESS 5a. DUTY ADDRESS 6. DATE OF CYCLE OR (0/P7) DATE 4b. HOME PHONE NO. (include Area Code) 5b. DUTY PHONE NO. a. DSN b. COMMERCIAL (include area code) 5a. NAME b. RELATIONSHIP c. DOB (YYYYMMDD) d. HOME ADDRESS a. NAME b. RELATIONSHIP c. DOB (YYYYMMDD) d. HOME ADDRESS b. RUTTARY PERSONNEL DIVISION/PERSONNEL c. RANK (Grade) d. SIGNATURE b. TITLE e. DATE (YYYYMMDD) e. DATE (YYYYMMDD) 9. NAME a. NOT b. CONSIDERATION c. SUBSTANTIAL CHANGE SINCE ENROL 9. NAME a. NOT b. CONSIDERATION c. SUBSTANTIAL CHANGE SINCE ENROL 9. NAME b. CONSIDERATION c. DATE SENT FOR CO	FAMILY MEMBER DEPLOYMENT SCREENING SHEET For use of this form, see AR 608-75; the proponent agency is OACSIM											
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2	SCREENING QUESTIONNAIRE For use of this form, see AR 608-75; the proponent agency is OACSIM														
			DATA REQUIRED												
	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 <u>et seq</u> .														
	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	SERVICE MEMBER'S NA	ME/RANK					DATE (YYYYMMDD)								
completes ALL blocks	BRANCH		UNIT			DUTY P	IONE								
on this page	PROJECTED PCS ASSIG	GNMENT	DSN	1		HOME P	HONE								
pugo	PROJECTED PCS DATE		HOME ADDRESS			DUTY AI	DRESS								
1 FORM															
FOR ALL FAMILY	LIST ALL	FAMILY MEMBE	RS	FAMILY MEMBER PREFIX	SEX	DA ()	CHECK IF ENROLLED IN EFMP								
MEMBERS		-													
			ANSWED ALL OU	ESTIONS . FOR F		EMBERS									
	PLEASE ANSWER ALL QUESTIONS - FOR FAMILY MEMBERS ONLY MEDICAL 1. Do any family members, excluding service member, have any medical records (<i>civilian or military</i>) other than the records YES NO you have provided us to screen? If yes, please list conditions/services received and address of provider.														
	FAMILY M	EMBER	CONDIT	IONS/SERVICES		NAME	NAME/ADDRESS OF PROVIDER								
		· .													
	2. In the past five (5) year hospitalization for normal	rs, have any memb uncomplicated chil	been hospitalized, excluding YES NO												
ł	NAM	E													
-															
t															
	3. Are any members of yo educational services from						ental health) or	YES	NO						
L	DA FORM 7246 . II IN 2009 PREVIOUS EDITION IS OBSOLETE. AF														

											•			
	regular basis?											ES	N	0
Dependent	\vdash	NAME						-		PRESCRIBED MEDICATION		_		
or Parent		-				-	-		THEODAIDED MEDICATION					
completes				1						and a first of the second s				-
ALL Blocks on this		n the past five (5) years, have any members of you ne following? (You will have an opportunity to disc	r fa	ami ss a	ily, e a// "Y	ES	udin " an	g s	ervi vers	ce member, been treated for, or had any problems with a screener.)	relat	ed t	o any	,
page 1 FORM	a.	Problems with sight (other than corrected by glasses)	ŀ	YE	S	T	10	1	g .	Asthma, allergies or other respiratory problems	YE	S	N	T
FOR ALL	b.	Problems with hearing	L			1		ŀ	1 .	Cerebral Palsy				T
FAMILY	C.	Heart condition	L	1	\square	+	+	ļ		Delayed Speech		\square		1
MEMBERS	d. e.	Seizure disorder	┝	L	4	1	1	H	· ·	Sickle Cell Trait/Disease	-	+	4	+
PLACE	e.	Loss of mobility (requiring use of a wheelchair/ walker or aid in mobility)			ונ	C		H	ι.	Cancer High blood pressure	+	Н	+	+
NAME OF	f.	Diabetes	+	Г		Т	Т	ť	n.	Other, if yes, explain	+	+	+	+
FAMILY		ITAL HEALTH:	-	-		-	-			outer, il yes, explain	1		1	-
MEMBER(s	6. Ir	the past five (5) years, have any members of your e following? (You will have an opportunity to discu	JSS	s a	1 "Y	ES'	an.	sw I	ervic ers	e member, been treated for, or had any problems m with a screener.)	-			
in the block	a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker	H	YE	5	N	0	6		Alcohol and drug use or abuse	YE		NC	, T
you	L	in reference to a mental health problem	-] [Fe		Emotional problems	+	H	+	Н
answered	b.	Depression		Г	TŤ	Т	Т	f		Behavioral problems/acting out behavior	+	Ħ	+	Ħ
YES	C.	Suicidal thoughts/ideas, gestures, attempts]	Г		g		Received therapy (marital, family, individual or group counseling)]]
	Resi	ave any members of your family, excluding service dential Treatment Center, Group Homes, Day Tre please explain:	at	me	mbe nt C	er, t ent	beers,	D	n any rug i	y of the following? Inpatient Psychiatric Facility, and Alcohol Treatment Rehabilitation Center. If	YES			j
						ED	DUC	A'		1				_
ir:		o any of your children now have, or have they even	-	-				e f	ollov	ving?				_
5	a.	Slow development (infants and preschoolers)		YE		N		d		Counseling services for school-related problems	YE		NO	
	b. Léarning problems (school)												_	Ή
	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 YES Education Plan (IEP))? If yes, who?													
	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.													
ς														
Signature										nderstand that it is my responsibility to provide any after the date indicated below, and prior to PCS m			ation	
of													9 B	
PARENT OR Dependent		TED NAME OF MILITARY SPONSOR OR JSE COMPLETING THIS FORM								ITARY SPONSOR OR SPOUSE DATE (YYYY FORM	MM	(00		1
	PRAC	TED NAME OF PHYSICIAN OR MEDICAL TITIONER IF UNDER THE SUPERVISION OF A SICIAN	F	PR/	ACT YSI	ITK	ONE	DF	PH IF L	YSICIAN OR MEDICAL INDER THE SUPERVISION OF A	MML	(D C)		
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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