EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) SCREENING QUESTIONNAIRE se of this form, see AR 608-75; the proponent agence

NAME OF MEDICAL TREATMENT FACILITY

For use of this	form, see AR 608	-75; the proponent a	gency is OACSIM									
		DATA REQUIRED	BY THE PRIVAC	Y ACT OF	1974							
AUTHORITY:	of 1978); DODI 13 (Provision of Med	efense Dependents' i december 1981; DOD deceive Special Educat 3; 20 USC 921-932 a	ODI 1010.13 cation in DOD									
PRINCIPAL PURPOSE:	To obtain informa This will permit co assignment proce	and medical needs of members in the perso	of family members. rsonnel									
ROUTINE USES:	Information will be medical needs of	nd document special	l education and									
DISCLOSURE:	The provision of requested information is mandatory. Failure to respond will preclude U.S. Total Personnel Command from enrolling soldiers in the EFMP. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. Refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.											
SERVICE MEMBER'S NA	AME/RANK			DATE (YYYYMMDD)								
BRANCH		UNIT			DUTY PHONE							
PROJECTED PCS ASSIG	GNMENT	DSN			HOME PHONE							
PROJECTED PCS DATE	<u> </u>	HOME ADDRESS			DUTY ADDRESS							
LIST ALI	FAMILY MEMBER PREFIX	SEX		TE OF BIRTH YYYYMMDD)	ENROL	CHECK IF ENROLLED IN EFMP						
	PLEASE	ANSWER ALL QU	ESTIONS - FOR F	AMILY M	EMBERS	ONLY						
Do any family member you have provided us to s	rs, excluding servicescreen? If yes, ple	ce member, have any ase list conditions/se	MEDICAL y medical records ervices received ar	(civilian or nd address	r military) o s of provide	ther than the records er.	s YES	NO				
FAMILY MEMBER CC			IONS/SERVICES		NAME/ADDRESS OF PROVIDER							
2. In the past five (5) yea hospitalization for normal				nember, b	een hospit	alized, excluding	YES	NO				
NAM		REASON										
3. Are any members of y educational services from						nental health) or	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										
													_
	the past five (5) years, have any members of ye following? (You will have an opportunity to come							rice member, been treated for, or had any problems s with a screener.)	rela	ited	to	any	
a. Problems with sight (other than corrected by glasses)			YE	S		NO	g.	Asthma, allergies or other respiratory problems	Y	ES	+	NC	<u>)</u>
b.	Problems with hearing						h.	Cerebral Palsy					
c.	c. Heart condition						i.	Delayed Speech	Ш				
d. Seizure disorder							j.	Sickle Cell Trait/Disease	Ц		_	_	1
e.	walker or aid in mobility)						k.	Cancer High blood pressure					
f.	Diabetes						m.	Other, if yes, explain					
MEN	TAL HEALTH:												
	the past five (5) years, have any members of ye following? (You will have an opportunity to d							rice member, been treated for, or had any problems is with a screener.)	rela	ted	to	any	
a. Referral to, diagnosed by, or therapy with a			ΥE	ES		NO			Y	ΈS		NC)
	Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem		Г	7			d.	Alcohol and drug use or abuse					
	The reserve to a memal meaning presion		L	_		Щ	e.	Emotional problems					
b.	Depression						f.	Behavioral problems/acting out behavior	Ш				
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:								Y [YES NO)]		
						FDU	CATIO	ON .	_				_
8. D	o any of your children now have, or have they	eve	r ha	ıd, a									_
a.			YE			NO		3	Υ	ΈS		NC	_)
	Slow development (infants and preschoolers	s)					d.	Counseling services for school-related problems					_]
b. c.	Learning problems (school) Special services (i.e., OT, PT, Speech, etc.)		e. Intellectual disability									_	_ 7
for special education			L			Ш		,	L			L	_ _
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?								Y [ES		NC)	
by Ar	my officials. Knowingly providing false inform	atior	in i	this	re	gard	may b	provide accurate information as required when required the basis for disciplinary or administrative action. olication for family travel or command sponsorship.					
famil		nt. <i>(A</i>	l fal	se d	offi	icial s	tatem	rovide false information, or who knowingly fail or re nent is a violation of Article 107, Uniform Code of M 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.										n			
PRINTED NAME OF MILITARY SPONSOR OR SPOUSE COMPLETING THIS FORM								MILITARY SPONSOR OR SPOUSE DATE (YY'	YYI	ИΜ	DD)	
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 (Y							YYYMMDD)						