

**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.

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
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

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 <input type="checkbox"/>	NO <input type="checkbox"/>
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.)								
a.	Problems with sight (other than corrected by glasses)	YES	NO	g.	Asthma, allergies or other respiratory problems	YES	NO	
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
b.	Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>	h.	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	i.	Delayed Speech	<input type="checkbox"/>	<input type="checkbox"/>	
d.	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	j.	Sickle Cell Trait/Disease	<input type="checkbox"/>	<input type="checkbox"/>	
e.	Loss of mobility (requiring use of a wheelchair/walker or aid in mobility)	<input type="checkbox"/>	<input type="checkbox"/>	k.	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
f.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	l.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	m.	Other, if yes, explain	<input type="checkbox"/>	<input type="checkbox"/>	
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.)								
a.	Referral to, diagnosed by, or therapy with a Psychiatrist, Psychologist, or Social Worker in reference to a mental health problem	YES	NO	d.	Alcohol and drug use or abuse	YES	NO	
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
b.	Depression	<input type="checkbox"/>	<input type="checkbox"/>	e.	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Suicidal thoughts/ideas, gestures, attempts	<input type="checkbox"/>	<input type="checkbox"/>	f.	Behavioral problems/acting out behavior	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	g.	Received therapy (marital, family, individual or group counseling)	<input type="checkbox"/>	<input type="checkbox"/>	
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 <input type="checkbox"/>	NO <input type="checkbox"/>	
EDUCATION								
8. Do any of your children now have, or have they ever had, any of the following?								
a.	Slow development (infants and preschoolers)	YES	NO	d.	Counseling services for school-related problems	YES	NO	
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
b.	Learning problems (school)	<input type="checkbox"/>	<input type="checkbox"/>	e.	Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Special services (i.e., OT, PT, Speech, etc.) for special education	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
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 <input type="checkbox"/>	NO <input type="checkbox"/>	
<p>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.</p> <p>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.</p> <p>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.</p>								
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)		