KLEBER HEALTH CLINIC

BLDG 3287 A, Kleber Kaserne
DSN: 483-1750; CIV: 0631-411-1750

EXCEPTIONAL FAMILY MEMBER PROGRAM PACKET

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Document instruction sheets

DA Form 5888

DA Form 7246

DD Form 2792(If necessary)

Kleber Clinic Contact Sheet

Mr. Gary Pack, RN
Case Coordinator.....DSN: 483-8724
CIV: 0631-411-8724

Mrs. Danielle Rinck, RN
Clinic Nurse.....DSN: 483-8724
CIV: 0631-411-8724

Aundrea Emerson
SPC, EFMP Tech.....DSN: 483-7675
CIV: 0631-411-1750

Appointment Line.....DSN 483-1750
CIV 0631-411-1750

Medical Personnel office.....DSN: 483-7675
CIV: 0631-411-7675

TRICARE-Landstuhl BLDG 3744
Foreign National Liaison DSN-486-6801/8849/6309/7915
CIV: 06371-86-6801/8849/6309/7915

TRICARE-Kleber BLDG 3245 RM 111.....DSN: 483-6358
CIV: 0631-411-6358

If you have any questions please call one of the above listed numbers.

EFMP FLOWCHART

What is the purpose of the appointment?

- I'm moving
  - Are you moving back to the US or to another OCONUS duty station?
    - Back to the US
      - Do you have family members enrolled in EFMP?
        - YES
          - Make an appt. w/ your primary care physician to update EFMP paperwork.
        - NO
          - No EFMP screening required to move CONUS.
    - Overseas Duty Station
      - Visit Clinic for EFMP SCN w/ EFMP Case Coordinator
- I need to update my enrollment/I need to disenroll a family member
  - Make an appt. w/ your PCM to update EFMP paperwork. DA-2792
- I have a new spouse
  - Have you had a phys/Pap in the past year?
    - No
      - Visit clinic For EFMP SCR/ Book appt for Phys/ Pap with PCM.
    - Yes
      - Visit Clinic for EFMP SCN w/ EFMP Case Coordinator
- I have a new baby
  - Do you already have command sponsored family members?
    - YES
      - Your new baby is automatically command sponsored and does not require an EFMP screening.
    - No
      - Visit Clinic for EFMP SCN w/ EFMP Case Coordinator

Everyone needing an EFMP Screening will need to complete a DA 5888 and DA 7246. The documents are included in your packet, or if needed you can come get extras from the Kleber Health Clinic.

EFMP PROCEDURES AND SCREENING GUIDE

Conditions that warrant Enrollment

- Soldiers who have family members with serious or chronic medical problems, physical disabilities, and mental heath disorders.
- Potentially life-threatening conditions including but not limited to asthma
- Continuous care or multiple episodes of care chronic (greater than 6 months) in nature
- Mental health treatment over past 5 years; or mental health services required at the present time or projected to the future.
- Attention Deficit Hyperactivity Disorder requiring management and treatment by a pediatrician, mental health care provider, or counselor.
- Follow-up support, such as high-risk newborns and patients with diagnosis of cancer within the past 5 years.
- Enroll all soldiers who have family members that require early intervention or special education services.

PROCEDURES

- SM or Spouse obtains DA Form 5888-R and 7246. Forms can be obtained from Form Flow, ACS, SM's PAC office or the Health Clinic.
- DA Form 7246 is to be completed by the SM or Spouse
- On DA Form 5888, the SM or Spouse completes items 1 – 7. **Next, the DA Form 5888 is then taken to the S1 at BDE or Garrison NOT Battalion level for Authentication (Item 8).**
- If only an update on a family member's EFMP is needed, DA Form 2792 and 7246 are the forms needed.
- If enrollment into the EFMP program is **NOT** warranted, bring all medical records and completed paperwork DA Form 5888 and DA Form 7246 to the Kleber Health clinic for processing. The Case Coordinator has one week to review the records.
- If enrollment into the program is warranted, contact the clinic's appointment line at DSN 483-1750/CIV 06314111750 to schedule an appointment with your PCM. During your appointment you must bring all medical records and completed paperwork.
- Once you have completed all necessary steps and appointments (if needed) then the case coordinator will provide the SM or Spouse with all necessary documentation and copies.

KLEBER CLINIC EFMP WORKSHEET

SPONSORS NAME_____ **SPONSOR SSN**_____

LOCATION OF NEXT DUTY STATION(IF APPLLICABLE)_____

DEROS_____

WHAT ARE YOU NEEDING TO DO TODAY? (Circle one)

ENROLL/DISENROLL UPDATE COMMAND SPONSORSHIP OTHER_____

NAME OF DEPENDENTS	DOB	PCM	RELATIONSHIP

_____

SIGNATURE

Before you arrive for your appointment, make sure you:

- Complete your Kleber Clinic EFMP Worksheet
- Retain copies of all medical records for the past 3 years (If your medical records are not held at a military treatment facility)
- Are your records translated?(If applicable) If they are NOT translated, you must have them translated BEFORE your appointment. (Include any ER visits and hospitalizations)
- Do you have a copy of your active medications FROM YOUR PROVIDER?(If your medical records are not at a military treatment facility)
- Do you have a copy of all recent Lab/Radiology results? (If your medical records are not held at a military treatment facility)
- Are your shot records included and up-to-date?
- Did you complete all areas of responsibility on your DA forms 5888 and 7246? (include DA form 2792 if you have dependents with special needs, enrollment/disenrollment EFMP)

EFMP FAQ

Q: What is the Exceptional Family Member Program (EFMP)?

A: The Exceptional Family Member Program or EFMP is a mandatory U.S. Department of Defense enrollment program that works with other military and civilian agencies to provide comprehensive and coordinated community support, housing, educational, medical, and personnel services worldwide to U.S. military families with special needs. Service members on active duty enroll in the program when they have a family member with a physical, developmental, or emotional or mental disorder requiring specialized services so their needs can be considered in the military personnel assignment process.

Q: How long does the EFMP process take?

A: If you have a dependent that warrants any special medical care (i.e. asthma, diabetes, learning disabilities, mental health issues etc.) then you must come to the Kleber Health Clinic to pick up your EFMP packet, gather and complete all necessary requirements and documents, schedule your appointment and show up **ON TIME**. Each case is different, but if you complete all of your requirements in a timely manner then the process will go by quickly and smoothly.

Q: What if my dependents do NOT have any special needs?

A: You need to completely fill out the DA 5888 and DA 7246. Once you complete your DA 5888 and DA 7246, you must return the documents to the Kleber Health Clinic. After you have dropped off your documents it will take up to **1 WEEK** for your paperwork to be reviewed and processed, so it is imperative that you turn in your documents in a timely manner.

Q: What is involved in the EFMP process?

A: If your dependent requires enrollment, you must gather all information requested and completely fill out the appropriate documentation. Once you have done that then you need to schedule an appointment with your PCM. **ALL FAMILY MEMBERS THAT REQUIRE ENROLLMENT WILL NEED A SEPARATE APPOINTMENT.** During your dependents appointment, your PCM will determine whether it will be beneficial for your dependents to live overseas (OCONUS) or if they must return stateside (CONUS).

If your dependent does not require enrollment, then it is as simple as completing documentation, turning them in on time and waiting 1 week for processing and completion

Q: How often do I need to perform an update to my EFMP enrollment?

A: Every three years or if there is an sufficient change in the to the medical or educational condition

Q: My family member no longer needs to be enrolled in EFMP, what do I do to get them disenrolled?

You must contact the case coordinator so the provider that your family member is being treated by can submit a DA Form 2792 recommending disenrollment from the program.

Q: My family member no longer qualifies as a family member

A: Provide documentation to show that they are no longer your family member so that disenrollment can take place.

Q: Who needs an EFMP screening?

A: Family members of Soldiers requesting **ITT** (Intratheater Transfer), **COT** (Continuous Overseas Tour), **IPCOT** (In-Place Continuous Overseas Tour), **CS** (Command Sponsorship), and **FSTE** (Foreign Service Tour Extension).

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.

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

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

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

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
PROJECTED PCS DATE	HOME ADDRESS	DUTY ADDRESS

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 ☐

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.

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)*