EXCEPTIONAL FAMILY MEMBER PROGRAM INFORMATION SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

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 identify the special education and medical needs of dependent children and medical needs of adult family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

ROUTINE USES: Information will be used by civilian personnel offices to determine the need for coordinating the availability of medically related services to meet the special needs of dependent children and medical needs of family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude--
(1) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs.

(2) Transportation of family members of Department of the Army civilian employees to duty assignments outside the United States at Government expense.

CONFIDENTIALITY: Information obtained will be maintained in strict confidence and provided only to those with an official need to know in identifying special needs and in processing personnel for assignments outside the United States.

PART A - GENERAL INFORMATION

ALL EMPLOYEES TAKING AN ASSIGNMENT IN A LOCATION OUTSIDE THE UNITED STATES WHERE FAMILY MEMBER TRAVEL IS AUTHORIZED AT GOVERNMENT EXPENSE MUST COMPLETE THIS FORM. EMPLOYEES WHO DO NOT HAVE FAMILY MEMBERS MUST COMPLETE BLOCKS 1-7 AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT BELOW.

1. SPONSOR'S NAME *(Last, first, MI)*	2. SPONSOR'S SOCIAL SECURITY NUMBER
3. SPONSOR'S TITLE	4. SPONSOR'S GRADE
5.a. SPONSOR'S HOME ADDRESS	6. SPONSOR'S HOME PHONE *(Include area code)*
5.b. SPONSOR'S DUTY ADDRESS	7. SPONSOR'S DUTY PHONE a. DSN b. COMMERCIAL *(Include area code)*

PART B - FAMILY MEMBERS AUTHORIZED TRAVEL OUTSIDE THE UNITED STATES

8. NAME *(Last, first, MI)*	9. RELATIONSHIP	10. DOB *(YYYYMMDD)*	11. SEX
a.			
b.			
c.			
d.			
e.			

12. PLEASE READ ALL OF THE FOLLOWING QUESTIONS VERY CAREFULLY AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT IN k. BELOW.

a. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LONG TERM *(i.e., more than one year's duration)* PHYSICAL OR EMOTIONAL ILLNESS?

b. ARE ANY OF THE ABOVE FAMILY MEMBERS BEING SEEN AT A HOSPITAL OR CLINIC REGULARLY? *("Regularly" means about every 2 months or more often and 4 or 5 times a year or more often.)*

c. WILL ANY OF THE ABOVE FAMILY MEMBERS NEED TO BE SEEN AT A HOSPITAL OR CLINIC OUTSIDE THE UNITED STATES REGULARLY BASED ON THEIR PRESENT MEDICAL CONDITION?

d. HAVE ANY OF THE ABOVE FAMILY MEMBERS BEEN TOLD THEY SHOULD BE SEEN REGULARLY AT A HOSPITAL OR CLINIC BUT ARE NOT BEING SEEN?

e. ARE ANY OF THE ABOVE FAMILY MEMBERS ENROLLED IN A SPECIAL EDUCATION PROGRAM?

f. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LEARNING DISABILITY?

g. ARE ANY OF THE ABOVE FAMILY MEMBERS BLIND, DEAF, OR HARD OF HEARING?

h. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A SPEECH PROBLEM THAT REQUIRES THE SERVICES OF A SPEECH THERAPIST?

i. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A PHYSICAL DISABILITY THAT COULD AFFECT THEIR LEARNING?

j. DO ANY OF THE ABOVE FAMILY MEMBERS REQUIRE PROFESSIONAL COUNSELING REGARDING PROBLEM BEHAVIOR, SUCH AS ABUSE OF ALCOHOL OR DRUGS, RUNNING AWAY, SKIPPING SCHOOL, OR OTHER DELINQUENT-TYPE ACTS?

k. SIGN ONE OF THE CERTIFICATIONS BELOW

(1) I CERTIFY THAT I DO NOT HAVE FAMILY MEMBERS.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*

(2) I CERTIFY THAT MY ANSWER TO EACH OF THE ABOVE QUESTIONS IS NO FOR EACH OF THE FAMILY MEMBERS LISTED ABOVE.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*

(3) I CERTIFY THAT ONE OR MORE OF MY ANSWERS TO THE ABOVE QUESTIONS IS YES REGARDING A FAMILY MEMBER LISTED ABOVE. *(Check appropriate block below)*

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL WITH ME CONCURRENTLY.

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL ON A DELAYED BASIS.

☐ I DO NOT INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL TO MY NEW DUTY LOCATION OUTSIDE THE UNITED STATES. I UNDERSTAND THAT A DA FORM 5862-R *(ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY)* AND DA FORM 5291-R *(ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY) (WHEN APPLICABLE)* MUST BE COMPLETED ON THE FAMILY MEMBER OR FAMILY MEMBERS AND PROVIDED TO THE CIVILIAN PERSONNEL OFFICE SHOULD I, AT A LATER DATE, DECIDE TO HAVE THE FAMILY MEMBER OR FAMILY MEMBERS JOIN ME AND THIS MUST BE ACCOMPLISHED PRIOR TO THEIR ARRIVAL AT THE LOCATION OUTSIDE THE UNITED STATES.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*