LEVY BRIEF EFMP OSS PACKET

Overseas Screening Step by Step

An overseas screening is a requirement for any dependents that will be accompanying an active duty soldier projected to be stationed OCONUS. OCONUS locations can be, but are not limited to, Alaska, Hawaii, Europe, and other non-US countries. Please note that EFMP enrollment is mandatory for any qualifying dependents identified during the overseas screening process

- ○ Receive orders from command to attend Levy Brief
- ○ Obtained a signed and dated copy of the DA 5888 from attending the Levy Brief
  Levy Brief Date: ____
- ○ Schedule a visit with PCM for an overseas physical. (Please note that if PCM is a civilian provider, we will need a copy of the physical note i.e. progress note.) Military Treatment Facility (MTF) appointments with your Martin Army Community Hospital PCM can be made by calling the appointment line at 762-408-2273
  Physical Appointment Date :____
- ○ Complete the OSS (overseas screening) packet. Please note that you will need a MEDCOM 756 and a DD form 2870 for each dependent on the DA form 5888.
- ○ Submit completed OSS packet, signed and dated DA 5888, and copy of physical notes to the EFMP office. Please feel free to e-mail the forms to usarmy.benning.medcom-bmach.mbx.bmach-efmp@mail.mil. You should receive an e-mail confirmation that it was received.
- ○ Once forms are received by the EFMP and a packet review is completed, a member of the EFMP staff will reach out to schedule the telephone based OSS Screening.
  Telephonic Appointment Date: ________________________________

EFMP HOURS OF OPERATIONS: Closed from 1200-1300 every day for lunch

****Holidays and Training holidays may influence regularly scheduled hours****

Monday	Tuesday	Wednesday	Thursday	Friday
CLOSED FOR ADMIN REVIEW	0900 TO 1600	0900 TO 1600	1030 TO 1600	0900 TO 1600

Appointment Line 762-408-2273 EFMP Front Desk 762-408-2423

EFMP E-mail: USARMY.BENNING.MEDCOM-BMACH.MBX.BMACH-EFMP@MAIL.MIL

Today's Date: _________________ **Report Date: __________________**

OVERSEAS SCREENING INTAKE SHEET

Sponsor's SSN: _________________________________ DOD#______________________________

Sponsor's Name (Last, First): _______________________________________ Rank: __________

SM's no#: ____________________________ Spouse's No#:________________________________

Where are Orders to: _____________________________________

Has Levy been done: Yes ____ No ____ Authenticated DA Form 5888: Yes___ No___

Family's Location: _________________________ Email :________________________________

EFMP Appointment: _______________________ Long Distance Phone Call: Yes___ No___

DEPENDENT INFORMATION

NAME	FMP	DOB	PHYSICAL DATE	MTF/ CIVILIAN

-Email Sent: Yes___ No___
-Received Physicals (Civilian) Yes___ No___

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

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 Martin Army Community Hospital

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
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)*

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*

5. TYPE OF TREATMENT *(X one)*
- [ ] OUTPATIENT
- [ ] INPATIENT
- [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE ______________________________ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
- [ ] PERSONAL USE
- [ ] INSURANCE
- [ ] CONTINUED MEDICAL CARE
- [ ] RETIREMENT/SEPARATION
- [ ] SCHOOL
- [ ] LEGAL
- [ ] OTHER *(Specify)*

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*

10. AUTHORIZATION EXPIRATION
- [ ] DATE *(YYYYMMDD)*
- [ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

SPONSOR NAME:
SPONSOR RANK:
FMP/SPONSOR SSN:
BRANCH OF SERVICE:
PHONE NUMBER:

MEDICAL RECORD - CONSENT FORM
Authorization To Send And Receive Medical Information By Electronic Mail

For use of this form see, MEDCOM Supplement 1 to AR 40-66; the proponent agency is MCHO

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER (Last four only)
4. E-MAIL ADDRESS		5. TELEPHONE NUMBER

SECTION II - CONDITIONS FOR USE OF E-MAIL

Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received. You must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Healthcare providers will respond within ____________________.
   Contact the clinic telephonically if you have not received a response after ____________________.
2. E-mail must be concise. You should schedule an appointment if the issue is complex or sensitive precluding discussion by E-mail.
3. E-mail should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases. HIV/AIDS, spouse or child abuse, chemical dependency, etc.
4. Medical or dental treatment facility staff may receive and read your messages.
5. E-mails related to health consultation will be copied, pasted, and filed.

SECTION III - RISKS OF USING E-MAIL

Transmitting information by E-mail has risks that you should consider these include, but are not limited to the following risks:

1. E-mails can be intercepted, altered, forwarded. or used without authorization or detection.
2. E-mails can be circulated, forwarded and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong E-mail address.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

SECTION IV - PATIENT GUIDELINES

To communicate by E-mail, the patient shall:

1. Place the category (topic) of the communication in the subject line of the E-mail (for example, appointment, prescription, medical advice, etc.)
2. Include the patient's name, telephone number, family member prefix, and the last 4 numbers of the sponsor's social security number (for example: 30/0858) in the body of the E-mail.
3. Acknowledge receipt of the E-mail when requested to do so by a health care provider.
4. Inform the medical or dental treatment facility of changes in E-mail address by completing a new consent form.
5. Notify the health care provider of any types of information considered by the patient to be inappropriate for E-mail.
6. Take precautions to preserve the confidentiality of E-mail.

SECTION V - PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the E-mail conditions and agree to abide by the guidelines listed above. I futher understand that this E-mail relationship may be terminated if I repeatedly fail to adhere to these guidelines.

I understand and accept the risks associated with the use of unsecure E-mail communications. I further understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth.

I understand that I have he right to revoke this authorization, in writing, at any time.

By signing this form I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent/ward for purpose of medical advice, education, and treatment.

(Date)	SIGNATURE of Patient or Parent/Guardian	RELATIONSHIP (if other than patient)

PATIENT IDENTIFICATION *(For typed or written entries note: Name-last, first, middle initial; hospital or medical facility)*

Patient's Name		Sex
Year of Birth	Relationship to Sponsor	Component/Status
Depart/Service	Sponsor's Name	
Rank/Grade	FMP-SSAN (Last four only)	
Organization		