Key: Filled by Service Member and/or Patient | Filled by Special Needs Coordinator | Filled by Chief of Medical Staff

REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATION CLEARANCE FOR TRAVEL

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical and educational needs of family members. This information will enable: (1) Military assignment personnel to authorize family member travel at government expense based on availability of needed services at the gaining installation; and (2) Civilian personnel offices to determine the availability of medical/educational services to meet the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for family travel/command sponsorship. Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority - Public 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.
This form will not be used for authorization to disclose psychotherapy notes, 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.

I authorize **52d Medical Group** (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.

Expiration Date: The authorization shall continue until you no longer meet the criteria to qualify as a dependent (active duty family members) or no longer desire to travel overseas at government expense (civilian employee family members), or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

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. 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. I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.

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.

SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT(S) *(If applicable)*	DATE *(YYYYMMDD)*
JD	Father	20200409
Jane Doe	Daughter	20200409

REQUEST FOR FAMILY MEMBER'S MEDICAL AND EDUCATION CLEARANCE FOR TRAVEL

(This Form is Subject to the Privacy Act of 1974 - USE BLANKET PAS - DD FORM 2005.)

SECTION I - SPONSOR'S DATA

A. NAME *(Last, First, Middle Initial)*	B. GRADE	C. SSN
Doe, John	E-5	000-00-0000

D. DUTY / HOME PHONE	E. PRESENT UNIT/LOCATION	F. CURRENT MPF LOCATION OF SPONSOR	G. MO/YR OF SPONSOR TRAVEL:
000-0000	MDSS/ Minot AFB, ND	Minot AFB	06 / 20

H. PROJECTED UNIT / LOCATION/PAS CODE	I. JOINT SPOUSE ASSIGNMENT	J. GAINING MAJCOM	K. PROJECTED AFSC	L. PREVIOUSLY Q-CODED
MDSS/ Spangdahlem	[ ] YES [X] NO		4A0x5	[ ] YES [X] NO

M. If Spouse is Active Duty: Name: Branch: SSN:

N. IS THE MEMBER BEING ASSIGNED TO STATE DEPARTMENT DUTIES OR OTHER GEOGRAPHICALLY REMOTE LOCATIONS? YES [ ] NO [X]

If family destination is other than a catchment area for an AF MTF, the sending installation must refer to EFMP-M guidance on areas of responsibility for remote clearances and embassy/attache' clearance processing.

SECTION II - FAMILY MEMBERS NOT TRAVELING

I hereby certify the following family members will NOT accompany me as command-sponsored dependents at any time during this assignment. I understand that if these plans change, I must reaccomplish this form to include the following family members and notify the Special Needs Coordinator at my current base of assignment..

FAMILY MEMBER'S NAME *(Last, First, Middle Initial)*	RELATIONSHIP	AGE

The above listed 0 ***(number)*** **family members will NOT accompany me at the gaining location.**

Sponsor's Signature JD

SECTION III - FAMILY MEMBERS REQUESTING COMMAND SPONSORSHIP TO TRAVEL

INSTRUCTIONS

Sponsors are required to list all family members requesting command sponsorship for the purpose of accompanying the military sponsor in the projected duty location. Page 3 of this form must be completed in its entirety for each family member listed to avoid delays in travel recommendation processing.

Additionally:

A. ALL sponsors with school-aged children, including those who are home-schooled, and those enrolled in Early Intervention who intend to travel OCONUS must complete DD Form 2792-1, Family Member Special Education/Early Intervention Summary. Attach copies of Individualized Education Plan (IEP) and/or Individualized Family Service Plan (IFSP), where applicable.

B. Sponsors must submit completed DD Form 2792, Family Member Medical Summary with Addendum 1, Asthma/Reactive Airway Disease Summary, Addendum 2, Mental Health Summary Addendum 3, Autism, for each family member with a special medical need who is requesting travel. If no special need is known for a family member, sponsor must check "None". OCONUS locations may require the use of these forms for travel considerations for ALL family members requesting OCONUS travel.

C. Sponsors must complete AF Form 1466D, *Dental Health Summary,* for all EFMP family members over the age of 2 traveling to any location and all members over the age of two traveling OCONUS. OCONUS locations may require the use of these forms for travel considerations for ALL family members requesting OCONUS travel.

D. Definitions:

1. Medical - Potentially life-threatening conditions and/or chronic medical/physical conditions within the last five years, requiring follow-up support more than once a year, or specialty care.
   Emotional/Behavioral - Any of the following: current or chronic mental health conditions; inpatient or intensive outpatient mental health services within the last 5 years; greater than one visit monthly for more than 6 months required at the present time. This includes medical care from any mental health provider, a primary care manager, other health care provider, or legal social service involvement.
2. Dental - Care beyond routine annual dental exam or cleaning.
3. Educational - Any child using or intending to use special education services, including any child with an IEP or an IFSP, or a child (aged birth - 3 years) with a high probability of having a developmental delay.
4. Early Intervention or Related Services - Occupational Therapy, Physical Therapy, Speech Therapy, Mental Health, Audiological, or other related services recommended on an IEP or IFSP for the support of appropriate education, as would be covered by State Part B or Part C Services under IDEA. Mark if ever received.
5. Modified Housing/Environmental modifications - Special housing requirements for documented needs, such as wheelchair accessibility.
6. None - No known medical conditions AND no specialized educational services needed. Requires only annual/semi-annual routine visits to primary care manager.

E. Location of medical records: For each family member listed in Section IV, indicate the location of stored medical records. Check "Copies Provided" if the sponsor and/or family member has provided copies of medical records not normally available through the MTF to support consideration of travel.

F. Month and Year of projected travel to Projected Location: Submit dates of travel of family members if different than travel date of sponsor shown in Section 1.G. above.

SPONSOR *(Last, First MI):* Doe, John SSN: 000-00-0000

SECTION IV - FAMILY MEMBERS REQUESTING COMMAND SPONSORSHIP TO TRAVEL *(Continued)*

FAMILY MEMBERS ACCOMPANYING SPONSOR — **CHECK ALL CONDITIONS THAT APPLY**

FAMILY MEMBER'S NAME *(Last, First, Middle Initial)*	RELATIONSHIP	AGE	GRADE IN SCHOOL	LOCATION OF MEDICAL RECORDS	COPIES PROVIDED	MONTH / YEAR OF TRAVEL	MEDICAL / EMOTIONAL / BEHAVIORAL	DENTAL	EDUCA - TIONAL	EI or RS SERVICES	MODIFIED HOUSING	NONE
Doe, Jane	Daughter	6	1	// Minot		06 / 20	x					
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SECTION V - CERTIFICATION OF APPLICANT

I certify that I have read and understand the previous instructions and that those entries made by me are true, complete, and correct to the best of my knowledge and belief.

Initials

JD I understand that I must inform the Special Needs Coordinator (SNC) of any changes to health/educational conditions prior to travel of family member listed in Section IV.

JD I understand that insufficient and/or inaccurate information may affect family member travel.

JD I understand that a knowing and willful false statement on this form can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ, Article 92 UCMJ).

JD I have disclosed to the SNC all known medical or special educational conditions for all family members planning travel.

JD I understand that failure to report these conditions may result in disciplinary action as a false official statement. Attempts to obtain a benefit, to include medical care or government sponsored travel by withholding information regarding my family member care histories may be reported to my commander.

JD I understand that choosing to take family members who are not recommended for government sponsored travel, at my own expense, may result in disciplinary action, significant personal expense, and may place family member in a location where necessary care or services are not available to them.

JD I understand I may request EFMP Reassignment via vMPF if one or more of my family members are not recommend for travel, or elect OCONUS travel unaccompanied.

DATE (YYYYMMDD)	PRINTED NAME AND GRADE OF SPONSOR	SIGNATURE
20200409	John Doe E-5	

SPONSOR NAME *(Last, First MI):* Doe, John **SSN:** 000-00-0000

SECTION VI - MEDICAL PROVIDER EVALUATION

Inquiry	YES	NO
A. All Family Members' Medical Records Reviewed? (If NO, comments required below).	☐	☐
B. All Family Members in Section IV Interviewed? (If NO, comments required below).	☐	☐
C. Special Medical Conditions Identified? (If YES, complete DD Form 2792).	☐	☐
D. All Family Members' AF Form 1466D reviewed? (If NO, comments required below).	☐	☐
E. Any unresolved dental care needs/problems identified on the AF Form 1466D?	☐	☐

I have confirmed the following presence or absence of specialty consultations and of pharmacy data indicating further review or potential special needs may be warranted. Comments required.

COMMENTS:

I have seen and interviewed all family members requesting travel and determined that FDI is ☐ is not ☐ required.

___ Number of DD Form 2792s attached. ___ Number of DD Form 2792-1s attached. ___ Number of AF Form 1466Ds attached

DATE (YYYYMMDD)	TYPE/PRINT NAME AND GRADE OF MEDICAL PROVIDER	SIGNATURE

SECTION VII - SPECIAL NEEDS COORDINATOR ENDORSEMENT

INQUIRY	YES	NO
A. History of Family Advocacy Involvement? *(If YES, complete DD Form 2792, Addendum 2)*	☐	☐
B. History of Mental Health Needs? *(If YES, complete DD Form 2792, Addendum 2)*	☐	☐
C. Has artificial openings / requires prosthetics? *(If YES, complete DD Form 2792. Ensure Part B, Section 8, is completed.)*	☐	☐
D. Requires Modified Housing? *(If YES, complete DD Form 2792. Ensure Part B, Section 9, is completed.)*	☐	☐
E. Requires Adaptive Equipment / Special Medical Equipment? *(If YES, complete DD Form 2792. Ensure Part B, Section 10, is completed.)*	☐	☐
F. Has Individualized Education Plan for Special Education? *(If YES, complete DD Form 2792-1)*	☐	☐
G. Has Individualized Family Service Plan or high probability for development delay. *(If YES, complete DD Form 2792-1)*	☐	☐

COMMENTS REQUIRED

DATE (YYYYMMDD)	TYPE/PRINT NAME AND GRADE OF SPECIAL NEEDS COORDINATOR	SIGNATURE

SECTION VIII - CERTIFICATION BY LOSING BASE MDG / SGH

Any YES response in Sections VI C or VII require forwarding this AF FORM 1466 to the gaining base for review via Facility Determination Inquiry.

Comments Required:

I have reviewed all information collected and find it sufficient for medical decision making.

Comments reviewed and determined that FDI is ☐ is not ☐ required.

___ Number of DD Form 2792s attached.
___ Number of AF Form 1466Ds attached.
___ Number of DD Form 2792-1s attached.

DATE (YYYYMMDD)	NAME & GRADE OF LOSING SGH	SIGNATURE

SPONSOR NAME *(Last, First MI):* Doe, John **SSN:** 000-00-0000

SECTION IX - FACILITY DETERMINATION INQUIRY, DISPOSITION BY MDG / SGH

Family member(s) travel is recommended.

Family member(s) require(s) FDI. **Note: Orders may not be issued until FDI completed by Gaining SGH.**

DATE (YYYYMMDD)	TYPE / PRINT NAME AND GRADE OF LOSING BASE SGH	SIGNATURE

Name of Losing Installation *(PRINT LEGIBLY)*

Family member(s) travel is recommended.

Family member(s) travel is not recommended.

ADDITIONAL COMMMENTS	Check all that apply:				
Family Member Name	Care available in MTF	Care available in local area	Care/Services not available	Recommend Care Coordination through PCS	Other

DATE (YYYYMMDD)	TYPE / PRINT NAME AND GRADE OF GAINING BASE SGH	SIGNATURE

Name of Gaining Installation *(PRINT LEGIBLY)*