

AIR FORCE SPECIAL NEEDS SCREENER

(Completed by all Sponsors with Family Members)

AUTHORITY: 10 U.S. 55. 10 U.S.C. 8013 and E.O. 9387 (SSN)

PURPOSE(S): Used to document, plan, and coordinate the health care of family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data.

ROUTINE USE: Used to accumulate information for determining family member special needs.

DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of family member's suitability for relocation at government expense or delay issuance of PCS orders.

TO: SPECIAL NEEDS COORDINATOR AND AIR FORCE PERSONNEL CENTER (AFPC)

FROM: Air Force Family Member Special Needs Identification Screener

The Air Force makes an effort to ensure specialized medical and educational services are available for all military family members. In order to help us do this, we need to know if any special medical and/or educational needs exist for your family members. You are required to complete this form as part of your relocation processing, if you have family members, whether they are living with you or not.

SPONSOR'S INFORMATION

_____ Sponsor's Name (Last, First, MI)	_____ Rank	_____ Social Security Number (SSN)
_____ Current Unit and Duty Station	_____ Duty Telephone Number	_____ Home Telephone Number
_____ Projected Installation For Relocation	_____ Projected Departure Date	

SPONSOR'S FAMILY INFORMATION

Please read and answer all questions. Indicate (X) the appropriate box. **Thank you.**

1. Are you currently enrolled in any Service's Exceptional Family Member Program (EFMP)? Yes No
- If yes, stop here.**
2. Do any of your children receive Special Education Services? Yes No
3. Do any of your children receive Early Intervention Services? Yes No
4. Do any of your children receive speech therapy, occupational therapy, physical therapy, or counseling services? Yes No
5. Has any dependent member of your family been hospitalized for the same condition more than once? Yes No
6. Has any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than six times in the last year? Yes No
7. Do any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist (such as cardiology, internist, psychology, neurology, counseling, etc.)? Yes No
8. Do any of your dependent family members have reactive airway disease or asthma? Yes No

If YES to any questions numbered 2 - 8, please contact the Special Needs Office at the Military Treatment Facility for assistance prior to pursuing any further relocation actions.

I certify that this information is complete and accurate to the best of my knowledge. I understand that insufficient and/or inaccurate information may affect family member travel at government expense. I understand that making a knowing and willful false official statement can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

Sponsor's Signature

Date