DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY, EUROPE, AND SEVENTH ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF, PERSONNEL
UNIT 29351
APO AE 09014

AEAGA-CE

20 DEC 2002

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Guidance on Processing Exceptional Family Member Program (EFMP) Forms for CONUS and Other Civilian Hires

References:

a. Army Regulation 608-75, 15 Oct 02, Exceptional Family Member Program.

b. Department of the Army Pamphlet 690-42, 4 Mar 88, Overseas Recruitment, Processing, and Medical Evacuation Procedures for Army Civilian Employees.

c. Army Regulation 690-300, Chapter 301, Overseas Employment.

d. Memorandum, HQ USAREUR/7A, AEAGA-CE, 22 Jan 99, subject: Overseas Outprocessing of Civilians and Identification of Exceptional Family Member Program (EFMP) Needs.

e. Memorandum, HQ USAREUR/7A, AEAGA-CE, 27 Sep 99, subject: Guidance for Processing Exceptional Family Member Program (EFMP) Forms for CONUS and Other Civilian Hires.

2. This memorandum rescinds reference (e) and provides guidance for screening civilians for EFMP needs when a tentative job offer is extended for an overseas position. This includes individuals recruited from CONUS, other overseas locations such as Korea, Japan, etc., or intra-theater (from one duty station to another in Europe) and local hires who receive logistical support. Screening is necessary due to the variation and availability of educational and medical-related services at the overseas locations.

3. The following guidance is provided in processing and completing DA EFMP forms. These forms must be completed by the overseas selectee **prior to a final job offer.**

a. No selectee should be allowed to travel to the overseas duty station or inprocess unless the following required DA EFMP forms are completed and coordinated with the Europe Regional Medical Command (ERMC) and Department of Defense Dependent Schools (DoDDS).

b. All US employees, except family members, must complete DA Form 5863-R (encl 1), EFMP Information Sheet, regardless of whether they have family members or not. If they do not have family member with medical/health or educational needs, they complete blocks 1-7 of DA Form 5863-R and sign the appropriate certification statement in section "k" of the form. The Civilian Personnel Advisory Center (CPAC) will forward completed original DA Form 5863-R to the Civilian Personnel Operations Center (CPOC) for filing on the left side of the Official Personnel Folder (OPF).

c. When there are family member medical and health needs, then the sponsor must also complete and return DA Form 5862-R (encl 2), Army Exceptional Family Member Medical Summary, to the CPAC.

d. When there are family member educational needs, then the sponsor must also complete and return DA Form 5291-R (encl 3), Army Exceptional Family Member Program Educational Summary, to the CPAC.

e. The CPAC will forward copies of the above forms to the following office by mail or fax:

Commander
Europe Regional Medical Command
Attention: MCEU-EFMP
CMR 442
APO AE 09042

FAX#: DSN 371-3376
Commercial: 49-(0)6221-173367

f. The ERMC EFMP Office will coordinate educational needs, upon receipt of the DA Forms 5862-R, 5863-R and/or 5291-R, with DoDDS-Europe. ERMC will forward the DA Form 5291-R to DoDDS-Europe. ERMC will forward the EFMP services screening sheet to the CPAC with information on where services are available in Europe to meet the need(s) identified.

g. After receiving the screening sheet from ERMC, the CPAC must provide the information to the selectee so the employee can make an informed decision, prior to accepting the job at the overseas duty station.

h. Once the employee accepts the final offer, the CPAC notifies the EFMP manager. The EFMP Managers will inform the ASG Commander when Exceptional Family Members (EFMs) of civilian employees are arriving at the new duty station where required services are unavailable. This information will be provided to the commander on a need to know basis only using e-mail.

4. Enclosed is a sample letter (encl 4) that can be used to notify tentative selectees of the availability of educational and medical-related services in the overseas area. Such a letter should be electronically transmitted, mailed or faxed to the selectee as soon as a tentative job offer is extended.

5. ERMC will maintain copies of the completed DA Forms 5863-R and the original 5862-R, only when a health/medical need has been identified. DoDDS-Europe will maintain the original DA Form 5291-R when an educational need has been identified. A statement that coordination was accomplished with the medical point of contact and/or DoDDS-Europe will be documented by the CPAC specialists on DA Form 5863-R. The CPAC will forward the original DA Form 5863-R to the Commander, US Army Community and Family Support Center, ATTN: CFSC-SFA, Alexandria, VA 22331-0521. DA Forms 5862-R, 5863-R and 5291-R are not filed in the employee's OPF if the sponsor has identified a medical/health or educational need.

6. HQ USAREUR/7A POC is Ms. Linda Reed, Policy Management Branch, 375-2539.

4 Encls
as

for JEANNIE A. DAVIS
Director of Civilian Personnel
United States Army, Europe

DISTRIBUTION:
Personnel Officer,
Benelux Civilian Personnel Advisory Center, ATTN: AEAGA-CBX, Unit 21419, APO AE 09708
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Heidelberg Civilian Personnel Advisory Center, ATTN: AEAGA-CHD, Unit 29351, Box 180, APO AE 09014-0180
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Director, IMA, Europe Region, (SFIM-EU-Z), Unit 29353, Box 200, APO AE 09014
Department of Defense Dependents Schools – Europe, Unit 29649, Box 7000, APO AE 09096
Commander, Headquarters, Europe Regional Medical Command, ATTN:
MCEU-EFMP, CMR 442, APO AE 09042
EFMP Program Managers,
6th Area Support Group, ATTN: Toma Garst, CMR 423, APO AE 09107
AST Garmisch, Unit 24515, APO AE 09053
22nd Area Support Group, Unit 31401, APO AE 09630
AST Livorno, Unit 31301, APO AE 09613
26th Area Support Group, Unit 29237, APO AE 09102
411th Base Support Battalion, ATTN: Ms. Cooper, Unit 29245, APO AE 09102
233rd Base Support Battalion, CMR 431, APO AE 09175
AST Babenhausen, CMR 462, APO AE 09089
293rd Base Support Battalion, ATTN: Ms. Filberth, Unit 29901, APO AE 09086
415th Base Support Battalion, ATTN: Ms. Serpa, Unit 23152, APO AE 09227
80th Area Support Group, ATTN: Ms. Prince, Unit 21419, APO AE 09708
254th Base Support Battalion, Unit 21602, APO AE 09714
AST NATO, ATTN: Ms. Reekie, PSC 79, APO AE 09714
98th Area Support Group, Unit 26622, APO AE 09244
417th Base Support Battalion, ATTN: Ms. Hamilton, Unit 26137, APO AE09031
280th Base Support Battalion, ATTN: Ms. Burlingame, CMR 457, APO AE09033
235th Base Support Battalion, ATTN: Ms. Scherer, Unit 28614, APO AE 09177
279th Base Support Battalion, ATTN: Ms. Gerstner, Unit 27535, APO AE09177
100th Area Support Group, ATTN: Ms. Scott, Unit 28130, APO AE 09114
409th Base Support Battalion, ATTN: Ms. Romero, Unit 28038, APO AE 09112
282nd Base Support Battalion, ATTN: Ms. Brockmann, Unit 28216, APO AE 09173
104th Area Support Group, Unit 20193, APO AE 09165
414th Base Support Battalion, ATTN: Ms. Yarborough, Unit 20193, APO AE 09165
284th Base Support Battalion, Unit 20911, APO AE 09169
AST Friedberg, ATTN: Ms. Ruzicka, CMR 453, APO AE 09074
AST Dexheim, CMR 406, APO AE 09110
222nd Baumholder, Unit 23746, APO AE 09034

EXCEPTIONAL FAMILY MEMBER PROGRAM INFORMATION SHEET

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

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)*

ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY

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

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552A)

AUTHORITY: PL 95-561 *(Defense Dependents' Education Act of 1978)*; PL 101-476 *(Individuals With Disabilities Education Act)*; PL 102-119 *(Individuals With Disabilities Education Act Amendments of 1991)*; DODI 1342.12 *(Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996; 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)*, August 28, 1986; 10 USC 3013, 20 USC 921 et seq. and 1400 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of: (1) Family members of all soldiers and (2) Family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

ROUTINE USES: (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --

(a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.

(b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children and medical needs of family members of Department of the Army civilian employees.

(2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude --

(1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program *(EFMP)*. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

(2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their family members transported to the duty assignment outside the United States at Government expense.

SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member's need for special education and medical services *(and for military personnel recommendations for my next assignment)*.

2. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE	3. DATE SIGNED

SECTION B - SPONSOR INFORMATION *(please print or type)*

4. NAME *(Last, First, MI)*		5. MILITARY DEPARTMENT AFFILIATION *(Specify if Civilian)*
6. RANK OR GRADE	**7. PRIMARY MOS/BRANCH/CIVILIAN OCCUPATIONAL SERIES**	**8. SOCIAL SECURITY NUMBER**
9. HOME ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**10. HOME PHONE** *(Include area code)*
11. DUTY ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		**12. DUTY PHONE** a. DSN b. COMMERCIAL *(Include area code)*
13. PROJECTED LOCATION OF NEXT ASSIGNMENT *(If known)*		**14. PROJECTED DATE OF NEXT ASSIGNMENT**

SECTION C - FAMILY MEMBER INFORMATION *(please print or type)*

15. NAME *(Last, First, MI)*	16. SEX	17. DATE OF BIRTH *(DDMMYYYY)*	18. FAMILY MEMBER PREFIX

DA FORM 5862-R, APR 97 EDITION OF AUG 95 IS OBSOLETE

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SECTION D - MEDICAL SUMMARY

(To be completed only by a physician or other designated medical practitioner)

MEDICAL PRACTITIONER. Please fill out this form as completely and as accurately as possible. Utilize ICD 9-CM or DSM-IV, if possible. List additional diagnoses and problems under "e" Explanation below.

19. DIAGNOSES AND CARE FREQUENCY

a. CURRENT ACTIVE DIAGNOSES	b. ICD-9/DSM-IV	c. SEVERITY A - Mild B - Moderate C - Severe	d. FREQUENCY OF CARE *(Insert appppropriate letter)* Y - Yearly Q - Quarterly M - Monthly W - Weekly D - Daily N - None Use 0 thru 9 for number of times Y, Q, M, W, D, N.	
			(1) Inpatient Care	(2) Outpatient Care

e. Explanation of diagnoses that are not described exactly as the ICD-9 or DSM-IV diagnosis:

20. CARE PROVIDERS. In column a, X the current medical providers essential for care of the patient. Use the same frequency codes as 19d. Column 20a is a mandatory entry.

a.	CODE	TYPE	b. FREQUENCY	a.	CODE	TYPE	b. FREQUENCY
	C01	Allergist			C28	Obstetrician	
	C02	Cardiologist, General			C29	Orthodonist	
	C03	Cardiologist, Pediatric			C30	Pediatrician	
	C04	Dentist			C31	Pedodonist	
	C05	Dermatologist			C32	Physiatrist	
	C06	Developmental Pediatrician			C33	Pulmonologist	
	C07	Dietary/Nutrition Specialist			C34	Podiatrist	
	C08	Endocrinologist, General			C35	Psychiatrist, General	
	C09	Endocrinologist, Pediatric			C36	Psychiatrist, Child	
	C10	Family Practitioner			C37	Psychologist, Clinical	
	C11	Gasteroenterologist, General			C38	Psychologist, Clinical w/Child Exp.	
	C12	Gasteroenterologist, Pediatric			C39	Rheumatologist, General	
	C13	General Medical Officer			C40	Rheumatologist, Pediatric	
	C14	Geneticist			C41	Transplant Team	
	C15	Gynecologist			C42	Surgeon, Cardio-thoracic	
	C16	Hemodialysis Team			C43	Surgeon, General	
	C17	Hematologist/Oncologist, General			C44	Surgeon, Neuro	
	C18	Hematologist/Oncologist, Pediatric			C45	Surgeon, Oral	
	C19	Immunologist			C46	Surgeon, Otorhinolaryngologist	
	C20	Internist			C47	Surgeon, Orthopedic, General	
	C21	Nephrologist, General			C48	Surgeon, Orthopedic, Pediatric	
	C22	Nephrologist, Pediatric			C49	Surgeon, Pediatric	
	C23	Neurologist, General			C50	Surgeon, Plastic	
	C24	Neurologist, Pediatric			C51	Urologist	
	C25	Nuclear Medicine Physician			C52	Other *(Specify)*	
	C26	Opthalmologist, General					
	C27	Opthalmologist, Pediatric					

21. ARTIFICIAL OPENINGS/SHUNTS *(X all that apply)*

	CODE	TYPE			
	F01	Gastrostomy		F05	Colostomy
	F02	Tracheostomy		F06	Ileostomy
	F03	CSF Shunt		F99	Other *(Specify)*
	F04	Cystostomy			

22. SERVICES REQUIRED *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	J01	Cognitive Enrichment Program		J10	Audiology Services
	J02	Program for Visually Impaired		J11	High Risk Newborn Follow-up Services
	J03	Social Work Services		J20	Standard Therapy for Speech/Language Impairments
	J04	Occupational Therapy		J21	Therapy for Hearing Impaired *(Includes signing)*
	J05	Community Health Nurse Services		J22	Total Communication Therapy *(Includes signing for hearing persons)*
	J06	Program for Oral Motor RX		J23	Augmentative Speech Therapy *(Uses Communication Devices)*
	J07	Apnea Monitor Home Program		J24	Alaryngeal Speech Therapy *(Rehabilitation after laryngeal surgery)*
	J08	Physical Therapy		J99	Other *(Specify)*
	J09	Community Mental Health Services			

23. ADAPTIVE EQUIPMENT NEEDS *(X all that apply)*

	CODE	TYPE		CODE	TYPE
	L01	Ambulatory Aids		L08	Wheelchair *(Manual)*
	L02	Communication Aids		L09	Cardiac Pacemaker
	L03	Apnea Monitor		L10	Wheelchair *(Electric)*
	L04	Hearing Aids/Auditory Trainer		L11	Augmentative Speech Aids
	L05	Artificial Limbs		L12	Home Oxygen Therapy
	L06	Respiratory Aids		L99	Other *(Specify)*
	L07	Braces/Splints			

24. ARCHITECTURAL CONSIDERATIONS *(X if applicable)* ☐ Limited Steps ☐ Complete Wheelchair Accessibility

25. MEDICATIONS *(List all medications required by the patient on a routine basis, including chemotherapy, radiation therapy, psychotropics and blood products. This block must be filled in with either medication or none.)*

26. Has this patient had cancer or leukemia in the past? ☐ YES ☐ NO

If yes, this patient has been disease-free for _____ years and has a _____ % chance of remaining disease-free.
The above statement should be completed only by a physician knowledgeable about the disease and its prognosis.

27. TREATMENT PLANNED *(Describe treatment or surgery planned or likely within the next 3 years, including expected duration. List any other problems or family circumstances that should be considered in the assignment of the sponsor. This block should be filled out in detail for any chronic disorder requiring weekly to monthly care or more than four specialists yearly)*

28. HAS THERE BEEN INTENSIVE MENTAL HEALTH CARE WITHIN THE LAST 5 YEARS? *(If yes, explain inpatient and/or outpatient care with emphasis on clinical course, compliance, prognosis, and participation of family members in treatment.)* ☐ YES ☐ NO

29. FUNCTIONAL DISABILITY SCALE

INSTRUCTIONS

1. The functional disability scale should be completed by the practitioner after discussion with the family member and review of medical records.

a. The functional disability scale records the impact the patient's disease process or disability is having on selected activities of daily living. These activities are listed as:

(1) Bathing, dressing, eating. This reflects ability to care for one's self in a manner appropriate for one's age.

(2) Quiet activity such as reading, playing a board game, doing handwork.

(3) Vigorous activity such as gym class in school, organized sports, hiking, etc.

(4) School or work. This reflects endurance and absences due to illness.

(5) Sleep. This reflects the frequency with which sleep is disrupted by the illness or disability.

(6) Socialization with peers such as conversations, going to the movies with one's peers, attending parent groups, etc.

b. The level of disability indicates the extent to which the activity is constrained or impacted by the illness or disability.

(1) None means none.

(2) Partial means the disability partly, but not completely, prevents or impacts the activity.

(3) Total means the disability totally prevents the activity from occurring.

c. Equipment assistance indicates those activities that are possible or greatly improved with the use of adaptive equipment or durable medical equipment. Examples would be a forearm prosthesis assisting with bathing, dressing, and eating, sleeping assisted with nasal prong oxygen, or a communication board assisting with socialization with peers.

d. Frequency of interference asks you to estimate how often the activity is compromised by the illness or disability.

2. The scale should reflect the ability of the patient to engage in the activities in comparision to his or her same aged, non-disabled peers. For instance, if 2-month-old infant has an illness that is *not impacting* his or her ability to eat in a manner comparable to non-disabled peers, that child would have "none" listed for level of disability under "bathing, dressing, eating" even though the infant is not independent in those activities.

a. Activity	b. Level of Disability *(Enter N - None, P - Partial, T - Total)*	c. Equipment *(Enter N - Not Used, U - Used)*	d. Frequency of Interference *(Enter appropriate letter and number: Y - Yearly, Q - Quarterly, M - Monthly, D - Daily, N - N/A. Use 0 - 9 for number of times Y, Q, M, D)*
(1) Bathing, Dressing, Eating			

SECTION E - ACKNOWLEDGEMENTS

30. **PATIENT OR SPONSOR:**
The above medical information has been reviewed and found to be accurate and complete.

a. SIGNATURE	b. DATE SIGNED

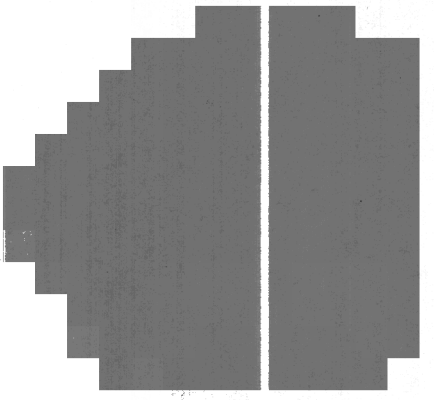
31. MEDICAL PRACTITIONER

a. TYPED OR PRINTED NAME OF MEDICAL PRACTITIONER COMPLETING THE DA FORM 5862-R	b. TELEPHONE NUMBER (1) DSN
c. ADDRESS OF MEDICAL PRACTITIONER *(Include Zip Code)*	(2) COMMERCIAL *(Include area code)*
d. SIGNATURE OF MEDICAL PRACTITIONER	e. DATE SIGNED

f. **PHYSICIAN'S AUTHENTICATION** *(To be signed when a medical practitioner other than a physician completes the DA Form 5862-R)*

g. TYPED OR PRINTED NAME OF PHYSICIAN	h. RANK OF PHYSICIAN *(typed or printed)*
i. TITLE OF PHYSICIAN *(typed or printed)*	j. GRADE OF PHYSICIAN *(typed or printed)*
k. SIGNATURE OF PHYSICIAN	l. DATE SIGNED

32. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY



33. FOR USE IN THE EFMP CODING PROCESS

a. Child is in residential treatment facility receiving medical care not available overseas; assign with individual case consideration. ☐ YES ☐ NO

b. Please enter disenrollment code *(if applicable)*: D - Death E - Educational condition no longer exists M - Medical condition no longer exists N - No longer meets requirements S - Separation/Retirement V - Divorce

c. NAME OF CODER *(Last, first, middle initial)*	d. MEDICAL TREATMENT FACILITY CODE

DA FORM 5862-R, APR 97
*U.S. G.P.O.:1997-418-329:20442

ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY

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

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552A)

AUTHORITY: PL 95-561 *(Defense Dependents' Education Act of 1978)*; PL 101-476 *(Individuals with Disabilities Education Act)*; PL 102-119 *(Individuals with Disabilities Education Act Amendments of 1991)*; DODI 1342.12 *(Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996; 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)*, August 28, 1986; 10 USC 3013; 20 USC 921 et seq. and 1400 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of:

(1) Family members of all soldiers.

(2) Dependent children of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

ROUTINE USES: (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --

(a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.

(b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children of Department of the Army civilian employees.

(2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude --

(1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program *(EFMP)*. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

(2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with dependent children with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their dependent children transported to the duty assignment outside the United States at Government expense.

SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member's need for special education and medical services *(and for military personnel recommendations for my next assignment)*.

2. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE	3. DATE SIGNED

SECTION B - SPONSOR INFORMATION *(please print or type)*

4. NAME *(Last, First, Middle Initial)*	5. MILITARY DEPARTMENT AFFILIATION *(Specify if Civilian)*	
6. RANK OR GRADE	7. PRIMARY MOS/BRANCH/CIVILIAN OCCUPATIONAL SERIES	8. SOCIAL SECURITY NUMBER
9. HOME ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		10. HOME PHONE *(Include Area Code)*
11. DUTY ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		12. DUTY PHONE a. DSN b. COMMERCIAL *(Include area code)*
13. PROJECTED LOCATION OF NEXT ASSIGNMENT *(If known)*		14. PROJECTED DATE OF NEXT ASSIGNMENT

DA FORM 5291-R, APR 97 EDITION OF JUL 93 IS OBSOLETE

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SECTION C - FAMILY MEMBER INFORMATION *(please print or type)*

15. NAME *(Last, First, Middle Initial)*	16. SEX	17. DATE OF BIRTH *(DDMMYYYY)*	18. FAMILY MEMBER PREFIX

SECTION D - EDUCATIONAL SUMMARY

TO BE COMPLETED BY EARLY INTERVENTION PROVIDER/SCHOOL PERSONNEL. This information is used by the Department of Defense in selecting a duty station, including overseas locations, for this child's military sponsor. Please provide complete and accurate information.

19. IS THIS STUDENT ELIGIBLE FOR EARLY INTERVENTION OR SPECIAL EDUCATION AS DESCRIBED IN INDIVIDUALS WITH DISABILITIES EDUCATION ACT? *(X one)*

		SIGNATURE	DATE SIGNED
	a. If "NO," do not complete the remainder of this form. Sign in block at right and return form to sponsor		
	b. If "YES," complete and sign items 19b thru 30, except for block 29.	SIGNATURE	DATE SIGNED

20. UNDER WHAT CRITERIA IS STUDENT ELIGIBLE FOR SPECIAL EDUCATION? ***(May only select 20a, 20b, or 20c)***

a. Ages 3-21 *(X all that apply)*

(X)	CODE		*(X)*	CODE		*(X)*	CODE	
	N07	Autistic		N04	Mentally Retarded		N06	Orthopedically Impaired
	N02	Blind			Mild to moderate		N08	Other Health Impaired
	N11	Visually Impaired			Moderate to severe *(trainable)*		N10	Seriously Emotionally Disturbed
	N01	Deaf			Severe to profound		N12	Specific Learning Disability
	N03	Hearing Impaired		N05	Traumatic brain injury		N09	Speech Impaired

b. Birth through age 2 *(infants and toddlers)*

☐ N13 Developmental Delay ☐ N14 At Risk for Developmental Delay

c. If student is enrolled in the Department of Defense Dependents Schools *(DODDS)*, under which criteria are they qualified for special education?

☐ Criterion A ☐ Criterion B ☐ Criterion C ☐ Criterion D ☐ Criterion E

21. PRESENT LEVEL OF PERFORMANCE *(X appropriate column to indicate student's present level in each area)*

CODE		(1) No Data	(2) Normal	(3) Mild Delay	(4) Moderate Delay	(5) Severe Delay
Q01	a. Self-Help					
Q02	b Gross Motor					
Q03	c. Fine Motor					
Q04	d Social					
Q05	e. Cognitive					
Q06	f. Expressive Language					
Q07	g Receptive Language					

h. Reading and Math Grade Levels ***(Use the following codes to indicate reading and math grade levels)***

O - kindergarten 9 - 9th grade A - 10th grade B - 11th grade C - 12th grade W - preschool
Y - no formal education Z - unknown

☐ Reading Grade Level ☐ Math Grade Level

22. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED EDUCATION PROGRAM *(IEP)* ***(X and complete, as applicable, all services currently received)***

CODE		*(X)*	(1) Duration of Contact *(Minutes)*	(2) Frequency of Contact *(D, W, M, Q, Y)*	(3) Select Highest Level of Intensity		
					Monitoring	Consult	Direct
S01	a. Audiology						
S02	b Counseling						
S03	c. Occupational Therapy						
S04	d Psychological Services						
S05	e. Physical Therapy						
S06	f. Therapeutic Recreation						
S07	g School Health Services						
S08	h Social Work Services						
S09	i. Speech Therapy						

23. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED FAMILY SERVICE PLAN *(IFSP)* *(X and complete as applicable, all services currently received)*

CODE		(X)	(1) Duration of Contact *(Minutes)*	(2) Frequency of Contact *(D, W, M, Q, Y)*	(3) Select Highest Level of Intensity		
					Monitoring	Consult	Direct
F10	a. Family Training/Counseling						
	b Special Instruction						
	c. Speech Language Pathology						
	d Occupational Therapy						
	e. Physical Therapy						
	f. Psychological Services						
	g Service Coordination						
	h Diagnostic Medical Services						
	i. Health Services						
	j. Vision Services						
	k. Social Work Services						
	l. Assistive Technology						
	m Transportation						

24. Special Transportation ☐ Wheelchair ☐ School Bus Attendant

25. Does student require wheelchair accessibility in school building? ☐ YES ☐ NO

26. Percentage of student's time spent in special education classes or resource room: _____ %

27. Does student require residential treatment in order to benefit from educational program? ☐ YES ☐ NO

[redacted]

28. STUDENT'S SPECIAL EDUCATION SERVICE DELIVERY SYSTEM CODE *(Please enter one of the following)*

A - Self-contained residential placement B - Self-contained residential placement in special school
C - Self-contained class in a community public school D - Special education setting for 60 percent or more of the time
E - Pull-out program or resource room program F - Co-teaching or inclusion model
G - Classroom teaching with technical assistance by service provider
H - Progress monitored by service provider

☐

29. OTHER COMMENTS

[redacted]

SECTION E - ACKNOWLEDGEMENTS

30. **SPONSOR OR SPONSOR'S SPOUSE:**

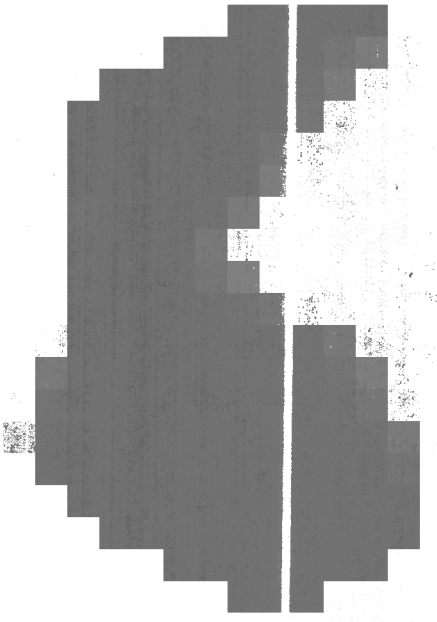
The above information has been reviewed and found to be accurate and complete.

a. SIGNATURE	b. DATE SIGNED

31. **SCHOOL PERSONNEL**

a. TYPED OR PRINTED NAME *(Last, First, MI)*	b. TITLE	c. TELEPHONE *(Include area code)*
d. NAME OF SCHOOL	**e. ADDRESS** *(Include Zip Code)*	**f. SCHOOL DISTRICT**
g. SIGNATURE		**h. DATE SIGNED**

31. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY



32. FOR USE IN THE EFMP CODING PROCESS:

a. Special medical needs that need to be coordinated with overseas command ☐ YES ☐ NO

b. Disenrollment code *(If applicable, please enter one of the following)*

D - Death E - Educational Condition No Longer Exists M - Medical Condition No Longer Exists
N - No Longer Meets Requirements S - Separation/Retirement V - Divorce ☐

c. NAME OF CODER *(Last, First, Middle Initial)*	d. MEDICAL TREATMENT FACILITY CODE

Sample Letter for Screening Civilian Exceptional Family Member Program Needs

Dear _____

This is a follow up to your recent tentative job offer as a (*insert title, series and grade*) in (*insert duty station*). The following requirements are in reference to the Exceptional Family Member Program (EFMP).

Prior to final acceptance of a position in an overseas duty station you must complete and return DA Forms 5863-R , 5862-R and 5291-R, Exceptional Family Member Program Information Sheet, Army Exceptional Family Member program Medical Summary and Army Exceptional Family Member Program Educational Summary. Completion of these forms is required so that if you have EFMP needs you will receive information about the availability of educational and medical- related services near the new duty station.

Educational and medical-related services provided by the U.S. Forces Medical facilities and the Department of Defense Dependent Schools (DoDDS) in Europe are limited in comparison to those available in the continental United States. If you have EFMP needs, it is our responsibility to inform you of available services so you may make an informed decision of whether to accept the job offer.

Please complete the above referenced forms and return them to (*include address of the office*) To ensure timely processing you may want to fax the forms to our office at (*include DSN and commercial fax number*). Forms are to be returned by ***(insert a date of return.).*** If you do not have access to a fax machine, check with your outprocessing point of contact for assistance.

If you have EFMP needs, DA Forms 5863-R, 5862-R and 5291-R will be forwarded to the EFMP staff at the Europe Regional Medical Command and will be coordinated with the DoDDS liaison person. After coordination, we will provide you with the latest DoDDS/EFMP service screening sheet that states whether special needs services are currently available at your duty station or in close proximity to your duty station. This information will allow you to decide if the services available meet with your needs.

Whether or not you have an exceptional family member will not affect your selection for the position. The purpose of collecting EFMP information is to provide you with advance information on educational and medical-related services so you may make an informed decision about accepting the position and to ensure a smooth transition for your family.

If you have additional questions, feel free to contact *(insert name of specialist handling action)* at *(insert telephone number and email address).*

Sincerely,

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