# EFMP Exceptional Family Member Program

AR 608-75 mandates that all Soldiers who have a Family member with an identified medical and/or educational condition must enroll in the Exceptional Family Member Program (EFMP). Soldiers are also responsible to update EFMP enrollment every three years; however, updates can also be made anytime the condition changes.

**To enroll and/or update EFMP medical enrollment:**

- Complete personal information on the DD Form 2792 (EFMP Medical Summary).
- [For Updates ONLY] Contact the Bayne-Jones Army Community Hospital (BJACH) EFMP at 337-531-3002 to request a copy of your EFMP Summary Report.
- Make an appointment with your Family member's Primary Care Manager (PCM) and bring your completed DD Form 2792 and EFMP Summary Report to the appointment.
- Following appointment with PCM, take the completed DD 2792 to the BJACH EFMP Special Needs +Advisor located in Family Practice, entrance B. The Special Needs Advisor will check for completeness and send paperwork to Atlantic Regional Medical Command to update EFMP medical enrollment.

**To enroll and/or update educational enrollment [for children on Individual Educational Plan (IEP)]:**

- Complete personal information on the DD Form 2792-1 (EFMP Special Education/Early Intervention Summary).
- Take DD Form 2792-1 to your child's Special Education Teacher to complete items 3-8 (on page 3).
- Once DD Form 2792-1 is complete, take it and a copy of your child's IEP to the BJACH EFMP Special Needs Advisor located in Family Practice, entrance B. The Special Needs Advisor will check for completeness and send paperwork to Regional Medical Command to update EFMP educational enrollment.

If your Family member needs to be disenrolled from the EFMP (i.e. the condition no longer exists, child no longer on IEP, divorce, etc.), please contact BJACH EFMP for more information on how to disenroll.

In the Fort Polk/JRTC Community, EFMP is here to assist you. **BJACH EFMP** can provide you with a copy of your EFMP Summary Report, information on enrollment/disenrollment, and will send your completed paperwork to Regional Medical Command for coding. **Army Community Service (ACS) EFMP Family Support Services** can provide you with information, support and advocacy once you are enrolled in the program. Please do not hesitate to contact us if you have questions or need more information.

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Bayne Jones Army Community Hospital
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# Provider Instructions for Completing the DD Form 2792

This document guides medical providers through the completion of the DD Form 2792, Family Member Medical Summary.

## Purpose of the DD Form 2792:

Families are **required** to complete the DD Form 2792 for two different reasons:

1. Document **medical needs for potential enrollment into the Exceptional Family Member Program (EFMP)**, which supports military families with special medical and / or educational needs.
2. Document the potential **travel concerns of a family member during Family Member Travel Screening (FMTS)**. This information will be coordinated with the gaining FMTS Office to determine the availability of medical services at the projected duty location.

## Who completes the DD Form 2792:

- ✓ The **Sponsor, Parent or Guardian, or Person of Majority Age** completes the demographics requested on the form.
- ✓ A **Qualified Medical Provider** is responsible for assessing whether the services they are eligible to prescribe are within the scope of their practice and their state licensing requirements. A Qualified Medical Provider may include a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), or Advanced Practice Nurse (APN).

## What to do after you complete the form:

- ✓ Return the form back to the family, who will route the form accordingly.

## Additional Tips for Completing the Form:

- ❖ Complete each block with as much detail as possible; this form will help determine other needs of the family (e.g. housing accommodations) as well as medical services needed by the family member.
- ❖ **Pages 2-3** are completed by the **Sponsor, Parent or Guardian, or Person of Majority Age** and **Administrative Staff**.
- ❖ **Page 3** should be certified **AFTER** the Qualified Medical Provider has completed the form and it has been reviewed by the Sponsor, Parent or Guardian, or Person of Majority Age for completeness, legibility, and accuracy.
- ❖ **Pages 4-8*** are completed and signed by the **Qualified Medical Provider**.
- ❖ Ensure that:
    - o The form is fully completed and legibly written or stamped,
    - o Frequency is noted properly on page 7* (MEDICAL SUMMARY, PART B), and
    - o The form is signed at the bottom of pages 4-8* and has the required contact information of the Qualified Medical Provider. Be sure to complete **all** items in the Provider Information section, as it is possible that the section may be split between pages.

**Please note that the total length of the form may increase based on the number of lines added to the Medications section for each diagnosis.*

Prescribed by: DoDI 1315.19

# FAMILY MEMBER MEDICAL SUMMARY
## INSTRUCTIONS FOR COMPLETING DD FORM 2792 FAMILY MEMBER MEDICAL SUMMARY

OMB No. 0704-0411
OMB APPROVAL EXPIRES 20230930

**GENERAL**

The DD Form 2792 is completed to identify a family member with special medical needs.

There is a Certification Section on page 3 that should be signed AFTER the entire form is completed by medical provider(s) and the form has been reviewed for completeness and accuracy.

The Parent / Guardian or Person of Majority Age signs block 9b, and the MTF case coordinator / authorized reviewer signs block 10b.

A Qualified Medical Provider is responsible for assessing whether the services they are eligible to prescribe are within the scope of their practice and their state licensing requirements.

**AUTHORIZATION FOR DISCLOSURE (Page 2)**

Health Insurance Portability and Accountability Act (HIPAA) Requirement

Each adult family member must sign for the release of his / her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority unless they are court-appointed guardians. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy / HIPAA coordinator about questions regarding authorizations for disclosure.

**DEMOGRAPHICS / CERTIFICATION (Page 3)**

**Item 1.** Select the appropriate purpose for filling out the form and provide documentation.

**Item 2.a.** Family Member / Patient Name. Name of family member described in subsequent pages.
**Item 2.b.** Sponsor Name. Name of the military member responsible for the family member identified in Item 2.a.
**Item 2.c. - e.** Self-explanatory.
**Item 2.f.** Family Member Prefix (FMP). Only applies to Military medical beneficiary. The FMP is assigned when the family member is enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).
**Item 2.g.** DoD Benefits Number (DBN). This 11-digit number has two components. The first nine digits are assigned to the sponsor; the last two digits identify the specific person covered under that sponsor. The first nine digits do not reflect the sponsor's nine-digit SSN. The DBN can be found above the bar code on the back of the beneficiary's ID card. If the child has not been issued an ID card, enter the first 9 digits of the parent's DBN.
**Item 2.h. - j.** Self-explanatory.

**Item 3.a. - h.** All items refer to the sponsor. Self-explanatory.
**Item 3.i.** Annotate whether the family member resides with the sponsor. If the family member does not, then provide an explanation.

**Item 4.a.** Answer "Yes" if both spouses are on active duty or if the enrolling spouse was a former member of the U.S. military. If "Yes," complete items 4.b. - e.

**Item 5.a. - d.** If "Yes," enter DoD ID #, name of sponsor and branch of Service. Military only.

**Item 6.a.** If "Yes," complete 6.b. - c. Self-explanatory.

**Item 7.** To be completed by the administrator in consultation with the family. Required Actions. Self-explanatory.

**Item 8.a. - c.** To be completed by the administrator in consultation with the family. Mark all services being provided to the family member.

**Item 9.a. - c.** Parent / Guardian or Person of Majority Age. Parent / Guardian or Person of Majority Age certifies that the information contained in the DD Form 2792 is correct. Individual must ensure that all applicable forms are completed and attached before signing.

**Item 10.a. - f.** The MTF authorized case coordinator / administrator name, signature, date, location of military treatment facility or certifying EFMP program, telephone number, and official stamp. Self-explanatory. Administrator must ensure that all forms are complete and attached before signing.

**MEDICAL SUMMARY beginning on page 4 must be completed by a Qualified Medical Provider. Sponsor, spouse, or family member of majority age must sign release authorization on page 2 before this summary is completed. Please complete as accurately as possible using the current International Classification of Diseases (ICD) Code(s).**

**Item 1.a. - b.** Diagnosis 1. Enter the diagnosis and corresponding diagnostic code for the family member.
**Item 1.c.** Prognosis. Self-explanatory.
**Item 1.d(1) - 1.d(4)** Medical History for the Last 12 Months. Enter the number of outpatient visits, emergency room visits / urgent care visits, hospitalizations, and ICU admissions.
**Item 1.e(1) - 1.e(3)** Medications. Enter all current medications associated with Diagnosis 1, the dosage and frequency medication should be taken.
**Item 1.f.** Treatment Plan for Diagnosis 1. Include medical and / or surgical procedures and special therapies planned or recommended over the next three years. Also include the expected length of treatment, required participation of family members, and if treatment is ongoing.

**Item 2.a.- f.** Diagnosis 2. Follow procedures for Items 1.a. - 1.f. above.

**Item 3.a. - f.** Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.

**Item 4.a. - 5.f.** Diagnoses 3 and 4. Follow procedures for Items 1.a. - 1.f. above.

**Item 6.a. - f.** Provider Information. Official stamp or printed name and signature of the provider completing this page, date the page was signed, telephone numbers for the provider, email, and medical specialty.

**Item 7.** History Associated with Asthma (if applicable). Answer "Yes" or "No", and include additional details as directed on the patient's asthma history for the last 5 years, as directed.

**Item 8.** History Associated with Behavioral Health (if applicable). Answer "Yes" or "No", and include additional details as directed on the patient's mental health history for the last five years, as directed.

**Item 9.** Current Intervention Therapies for Autism Spectrum Disorders and / or Significant Developmental Delays (if applicable).

**Item 10.** Communication. Indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

**Item 11.** Other Interventions / Therapies Used by the Family. Self-explanatory.

**Item 12.** Behavior. Answer "Yes" if the child exhibits high risk or dangerous behaviors.

**Item 13.a. - c.** Provider Information. Official stamp or printed name and signature of provider completing the page and date the page was signed.

**Item 14.** Health Care Required. In column 1, mark any specialists REQUIRED to meet the patient's needs. If a specialist was used to determine a diagnosis and is not necessary for ongoing care, DO NOT place an X next to that specialist. If a developmental pediatrician is a child's primary care manager, but a pediatrician meets the needs, DO NOT mark developmental pediatrician. This section should reflect the providers that are necessary to meet the needs of the patient.

**Item 15. - 20.** Self-explanatory.

Prescribed by: DoDI 1315.19

# FAMILY MEMBER MEDICAL SUMMARY

*(To be completed by Service member, adult family member, or civilian employee. Read Instructions before completing this form.)*

OMB No. 0704-0411
OMB APPROVAL EXPIRES 20230930



## PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 136, 20 U.S.C. 927; DoDI 1315.19; DoDI 1342.12.

**PRINCIPAL PURPOSE(S):** Information will be used by DoD personnel to evaluate and document the special medical needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the special medical needs of family members against the availability of medical services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices to advise civilian employees about the availability of medical services to meet the special medical needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files.

The applicable SORNs and routine uses that apply can be found at: Air Force: F036 AF PC C, Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569821/f036-af-pc-c/; F044 AF SG U: Special Needs and Educational and Developmental Intervention Services at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569875/f044-af-sg-u/; Army: A0600-8-104b AHRC - Official Military Personnel Record at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570654/a0600-8-104b-ahrc/; A0608b CFSC, Personnel Affairs Army Community Service Assistance Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570384/a0608b-cfsc/
DHA: EDHA 07: Military Health Information System at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570572/edha-07/
OSD/JS: DMDC 02 DoD: Defense Enrollment Eligibility Reporting Systems (DEERS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570618/dmdc-02-dod/
DPR 34 DoD: Defense Civilian Personnel Data System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570697/dpr-34-dod/
EDHA 16 DoD: Special Needs Program Management Information System (SNPMIS) Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570579/edha-16-dod/
DoDEA 29: DoDEA Non-DoD Schools Program at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570576/dodea-29/
DoDEA 26: Department of Defense Education Activity Educational Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570573/dodea-26/
Navy and Marine Corps: M01070-6: Marine Corps Official Military Personnel Files at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/
M01754-6: Exceptional Family Member Program Records at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/
N01070-3: Navy Military Personnel Records System at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/
N01301-2: On-Line Distribution Information System (ODIS) at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570320/n01301-2/

**DISCLOSURE:** Voluntary for civilian employees and applicants for civilian employment. 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. The DoD Identification (DoD ID) number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any special medical needs of your dependent can be met at your next duty assignment. Dependent special needs are annotated in the official military personnel files which are retrieved by name and DoD ID number.

## AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Per DoD Instruction, Service members are required to enroll in the EFMP if they have a family member with a qualifying medical condition. Accordingly, the Sponsor will have access to the health information contained herein during the accomplishment and submission of this application. By signing the below authorization for disclosure of medical information you acknowledge your sponsor may have access to the health information contained herein. The authorization for sponsor access is terminated once the application is received by EFMP. The sponsor may be held accountable for the accuracy and completeness of the DD Form 2792 and should review all pages prior to signing on page 2.

I authorize _____ *(MTF / DTF / Civilian Provider) (Name of Provider)*

to release my patient information to the Exceptional Family Member Program (EFMP) medical / the Family Member Travel Screening (FMTS) Office and EFMP Family Support Office. This information may be used for enrollment into the EFMP, the family travel review process, and / or community support services to determine whether there are adequate medical, housing, and community resources to meet your needs at the sponsor's proposed duty location, and / or to assist family members with community support at the current and/or projected duty location.

a. The military medical department or appropriate headquarters family support office will use the information to determine whether you meet the criteria for enrollment into the EFMP and the military medical departments will provide recommendations on the availability of care in communities where the sponsor may be assigned or employed.
b. Information that you have a special medical need (not the nature or scope of the need) may be included in the sponsor's personnel record, if EFMP enrollment criteria are met.
c. Information may be shared with EFMP Family Support staff who assist the family and / or sponsor with appropriate community resources.
d. The authorization applies to the summary data included on the medical summary form, and subsequent updates to information on this form. If additional clarification or information is needed, I authorize review of my health record, which may be maintained in an electronic format. This information may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives of the medical departments, the offices responsible for enrollment into the Exceptional Family Member Program, the offices responsible for assignment coordination, the offices responsible for EFMP Family Support services, and, at your request, other agents responsible for care or services. Summary data may be transmitted (e.g. encrypted electronic mail or faxing) using authorized secure media transfer.

**Start Date:** The authorization start date is the date that you sign this form authorizing release of information.
**Expiration Date:** The authorization shall continue until enrollment in the Exceptional Family Member Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, or if family member no longer meets the criteria to qualify as a dependent, or the sponsor is no longer in active military service or in the employment of the U.S. Government overseas, or completion of assignment coordination, or eligibility determination for specialized services if that is the sole purpose for the completion of the form.

I understand that:
a. Failure to release this information or any subsequent revocation may result in ineligibility for accompanied family travel at government expense.
b. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my or my child's 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 protected information on the basis of this authorization. My revocation will have no impact on disclosures made prior to the revocation.
c. If I authorize my or my child's 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.
d. I have a right to inspect and receive a copy of my own or my child's 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 for the stated purposes.
e. Refusal to sign does not preclude the provision of medical and dental information authorized by other regulations and those noted in this document.

| NAME OF PATIENT | SIGNATURE OF PATIENT / PARENT / GUARDIAN | RELATIONSHIP TO PATIENT *(if applicable)* | DATE *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

Prescribed by: DoDI 1315.19

| FAMILY MEMBER / PATIENT NAME (Last, First, Middle Initial) | SPONSOR NAME (Last, First, Middle Initial) | SPONSOR DoD ID # |
|---|---|---|
| | | |

**DEMOGRAPHICS / CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient**

**1. PURPOSE OF THIS FORM** *(Select One)*

- ☐ EFMP Enrollment or Update
- ☐ Request for Government Sponsored Travel
- ☐ Request Change in EFMP Status:
  - ☐ No Longer Have Previously Identified Condition
  - ☐ No Longer Qualifies as Dependent
  - ☐ Family Member Deceased
  - ☐ Divorce / Change in Custody

*(Provide documentation to verify change in status.)*

| 2a. FAMILY MEMBER / PATIENT NAME (Last, First, Middle Initial) | 2b. SPONSOR NAME (Last, First, Middle Initial) | 2c. SPONSOR DoD ID # |
|---|---|---|
| | | |

| 2d. FAMILY MEMBER GENDER (Select One) | 2e. FAMILY MEMBER DATE OF BIRTH (YYYYMMDD) | 2f. FAMILY MEMBER PREFIX (FMP) | 2g. DoD BENEFITS NUMBER (DBN) (On Back of ID Card) |
|---|---|---|---|
| ☐ Male ☐ Female | | | |

| 2h. CURRENT FAMILY MEMBER MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO / FPO) | 2i. HOME TELEPHONE NUMBER (Include Country Code / Area Code) |
|---|---|
| | 2j. FAMILY HOME E-MAIL ADDRESS |

| 3a. SPONSOR RANK OR GRADE | 3b. DESIGNATION / NEC / MOS / AFSC (Military Only) | 3c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT |
|---|---|---|
| | | |

**3d. BRANCH OF SERVICE** *(Military Only)*

☐ Army ☐ Navy ☐ Air Force ☐ Marine Corps ☐ Coast Guard

**3e. STATUS** *(Select One)*

☐ Regular Active Service Member ☐ Active Reserve ☐ Active Guard ☐ Reserves ☐ National Guard ☐ Civilian

| 3f. SPONSOR'S OFFICIAL E-MAIL ADDRESS | 3g. DUTY TELEPHONE NUMBER | 3h. MOBILE NUMBER (Include Country Code / Area Code) |
|---|---|---|
| | | |

**3i. DOES FAMILY MEMBER RESIDE WITH SPONSOR?** *(Select One. If "No," Explain.)*

☐ Yes ☐ No

**4a. ARE YOU DUAL MILITARY** ☐ **OR IS YOUR SPOUSE FORMER MILITARY?** ☐ *(Military Only. If either is selected, complete 4b. - 4e. below.)*

| 4b. SPOUSE'S NAME (Last, First, Middle Initial) | 4c. BRANCH OF SERVICE | 4d. RANK / RATE | 4e. SPOUSE DoD ID # |
|---|---|---|---|
| | | | |

**5a. HAS THE FAMILY MEMBER EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR DoD ID #?** *(Select One.)*

| ☐ Yes ☐ No | 5b. IF "YES," UNDER WHAT DoD ID #? | 5c. UNDER WHAT SPONSOR'S NAME ? (Last, First, Middle Initial) | 5d. BRANCH OF SERVICE |
|---|---|---|---|
| | | | |

**6a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES?** *(Select One)*

☐ Yes ☐ No *(If "Yes," Complete 6b. and 6c.)*

**6b. LOCATION OF CASE MANAGER** *(Select One)* ☐ MTF ☐ TRICARE ☐ Civilian

**6c. CASE MANAGER CONTACT INFORMATION**

| 6c(1). NAME (Last, First, Middle Initial) | 6c(2). E-MAIL ADDRESS (If Available) | 6c(3). TELEPHONE NUMBER (Include Country Code / Area Code) |
|---|---|---|
| | | |

**FOR ADMINISTRATIVE USE ONLY**

**7. REQUIRED ACTIONS** *(Select One)*

- ☐ First Review of Medical History for the Family Member
- ☐ Request for Government Sponsorship / Family Travel
- ☐ Update to a Previous Evaluation for the Family Member
- ☐ Other (e.g., *Extended Care Health Option (ECHO) Eligibility*)
- ☐ Qualifies for Change in EFMP Status:
  - ☐ Family Member No Longer Has Previously Identified Condition
  - ☐ Family Member Deceased*
  - ☐ Family Member No Longer Qualifies as a Dependent*
  - ☐ Divorce / Change in Custody*

*(*Maintain documentation to verify change in status - do not update medical information.)*

**8. SPECIAL ASSIGNMENT CONSIDERATIONS** *(Mark all that apply)*

- ☐ 8a. Possible Special Education / Early Intervention *(If checked, DD Form 2792-1 must be completed.)*
- ☐ 8b. Receiving TRICARE Extended Care Health Option (ECHO) Benefits
- ☐ 8c. Receiving State Medicaid / Medicare Waiver Services

**CERTIFICATION**

**9. CERTIFICATION.** DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM.
By signing below, we certify that the information submitted on this DD Form 2792 is complete and accurate.

**PARENT / GUARDIAN OR PERSON OF MAJORITY AGE**

| 9a. PRINTED NAME (Last, First, Middle Initial) | 9b. SIGNATURE | 9c. DATE (YYYYMMDD) | 10f. OFFICIAL STAMP |
|---|---|---|---|
| | | | |

**10. ADMINISTRATIVE CERTIFICATION**

| PRINTED NAME (Last, First, Middle Initial) | 10b. SIGNATURE | 10c. DATE (YYYYMMDD) | |
|---|---|---|---|
| | | | |

| 10d. LOCATION OF MILITARY TREATMENT FACILITY OR CERTIFYING EFMP OFFICE | 10e. TELEPHONE NUMBER (Include Country Code / Area Code) | |
|---|---|---|
| | | |

Prescribed by: DoDI 1315.19

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY: To be completed by a Qualified Medical Provider**

**PART A - PATIENT STATUS** *(Authorization by patient or parent / guardian included on Page 2 of this form.)*

Please complete as accurately as possible using the current ICD Code(s).

**DIAGNOSIS INFORMATION**

| 1a. DIAGNOSIS 1 | 1b. ICD CODE |
|---|---|
| | |

**1c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**1d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 1)*

| 1d(1). NUMBER OF OUTPATIENT VISITS | 1d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 1d(3). NUMBER OF HOSPITALIZATIONS | 1d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**1e. MEDICATIONS**

| 1e(1). CURRENT MEDICATION(S) | 1e(2). DOSAGE | 1e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**1f. TREATMENT PLAN FOR DIAGNOSIS 1** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

| 2a. DIAGNOSIS 2 | 2b. ICD CODE |
|---|---|
| | |

**2c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**2d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 2)*

| 2d(1). NUMBER OF OUTPATIENT VISITS | 2d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 2d(3). NUMBER OF HOSPITALIZATIONS | 2d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**2e. MEDICATIONS**

| 2e(1). CURRENT MEDICATION(S) | 2e(2). DOSAGE | 2e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**2f. TREATMENT PLAN FOR DIAGNOSIS 2** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

**PROVIDER INFORMATION**

| 3a. PROVIDER PRINTED NAME OR STAMP | 3b. SIGNATURE | 3c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| 3d. TELEPHONE NUMBERS *(Include Country Code / Area Code)* | | 3e. OFFICIAL EMAIL ADDRESS | 3f. MEDICAL SPECIALTY |
|---|---|---|---|
| 3d(1). COMMERCIAL | 3d(2). DSN *(Military Only)* | | |
| | | | |

Prescribed by: DoDI 1315.19

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY** *(Continued)*: **To be completed by a Qualified Medical Provider**

**PART A - PATIENT STATUS** *(Continued)*

Please complete as accurately as possible using the current ICD Code(s).

**DIAGNOSIS INFORMATION**

**4a. DIAGNOSIS 3** | **4b. ICD CODE** [ ][ ][ ].[ ][ ][ ][ ]

**4c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**4d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 3)*

| 4d(1). NUMBER OF OUTPATIENT VISITS | 4d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 4d(3). NUMBER OF HOSPITALIZATIONS | 4d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**4e. MEDICATIONS**

| 4e(1). CURRENT MEDICATION(S) | 4e(2). DOSAGE | 4e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**4f. TREATMENT PLAN FOR DIAGNOSIS 3** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

**5a. DIAGNOSIS 4** | **5b. ICD CODE** [ ][ ][ ].[ ][ ][ ][ ]

**5c. PROGNOSIS** *(Select One)* ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

**5d. MEDICAL HISTORY FOR THE LAST 12 MONTHS** *(Associated with Diagnosis 4.)*

| 5d(1). NUMBER OF OUTPATIENT VISITS | 5d(2). NUMBER OF ER VISITS / URGENT CARE VISITS | 5d(3). NUMBER OF HOSPITALIZATIONS | 5d(4). NUMBER OF ICU ADMISSIONS |
|---|---|---|---|
| | | | |

**5e. MEDICATIONS**

| 5e(1). CURRENT MEDICATION(S) | 5e(2). DOSAGE | 5e(3). FREQUENCY |
|---|---|---|
| | | |
| | | |

**5f. TREATMENT PLAN FOR DIAGNOSIS 4** *(Medical, mental health, surgical procedures or therapies provided in the last 12 months, or planned or recommended over the next three years. For cancer patients, include date of diagnosis, types of treatment, responses to treatment, if treatment is active and if treatment is completed.)*

**PROVIDER INFORMATION**

| 6a. PROVIDER PRINTED NAME OR STAMP | 6b. SIGNATURE | 6c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| 6d. TELEPHONE NUMBERS *(Include Country Code / Area Code)* | | 6e. OFFICIAL EMAIL ADDRESS | 6f. MEDICAL SPECIALTY |
|---|---|---|---|
| 6d(1). COMMERCIAL | 6d(2). DSN *(Military Only)* | | |
| | | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY** *(Continued)*: **To be completed by a Qualified Medical Provider**

**PART A - PATIENT STATUS** *(Continued)*

**ADDITIONAL INFORMATION FOR ASTHMA, BEHAVIORAL HEALTH, AND AUTISM SPECTRUM DISORDERS AND / OR SIGNIFICANT DEVELOPMENTAL DELAYS**
*(Complete if patient has been evaluated or treated for asthma (within the past five years), a behavioral health condition (within the past five years) and / or autism spectrum disorders and / or significant developmental delays.)*

**ASTHMA INFORMATION** ☐ N/A

**7. HISTORY ASSOCIATED WITH ASTHMA** *(See note above for additional information) (Select as applicable)*

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 7a. ARE THERE ANY TRIGGERS FOR THE PATIENT'S ASTHMA EXACERBATIONS? *(If "Yes," specify exact trigger(s))* |
| ☐ | ☐ | 7b. HAS THE PATIENT EVER TAKEN ORAL STEROIDS DURING THE PAST YEAR FOR EXACERBATIONS? *(prednisone, prednisolone)* If "YES", NUMBER OF COURSES IN THE PAST YEAR: |
| ☐ | ☐ | 7c. HAS THE PATIENT REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES", INDICATE THE NUMBER OF VISITS IN THE PAST YEAR: |
| ☐ | ☐ | 7d. DOES THE PATIENT HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST FIVE YEARS? IF "YES," HOW MANY? _____ INDICATE DATE OF LAST ADMISSION: *(YYYYMMDD)* _____ |
| ☐ | ☐ | 7e. DOES THE PATIENT HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS? |

**BEHAVIORAL HEALTH INFORMATION** ☐ N/A

**8. HISTORY** *(Select and provide details for each "Yes" answer)*

| YES | NO | WITHIN THE LAST 5 YEARS, HAS THE PATIENT HAD A: |
|---|---|---|
| ☐ | ☐ | 8a. HISTORY OF SUICIDAL BEHAVIORS / ATTEMPTS? *(If "Yes," include dates)* |
| ☐ | ☐ | 8b. HISTORY OF SUBSTANCE MISUSE / ABUSE? |
| ☐ | ☐ | 8c. HISTORY OF ADDICTIVE BEHAVIORS? |
| ☐ | ☐ | 8d. HISTORY OF EATING DISORDERS? |
| ☐ | ☐ | 8e. HISTORY OF OTHER COMPULSIVE BEHAVIORS? |
| ☐ | ☐ | 8f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY OR AUTHORITY FIGURES? *(If "Yes," specify)* |
| ☐ | ☐ | 8g. HISTORY OF PSYCHOTIC EPISODES? |
| ☐ | ☐ | 8h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? *(If "Yes," and services are delivered by Family Advocacy, note case determination)* |

**CURRENT INTERVENTION THERAPIES FOR AUTISM SPECTRUM DISORDER AND / OR SIGNIFICANT DEVELOPMENTAL DELAYS** ☐ N / A

| 9a. TYPE *(To be completed by a Qualified Medical Professional in consultation with the family)* | 9b. SCHOOL OR EARLY INTERVENTION HOURS / WEEK *(If known)* | 9c. TRICARE HOURS / WEEK *(If known)* | 9d. OTHER SOURCE HOURS / WEEK *(If known)* | 9e. OTHER *(Identify)* |
|---|---|---|---|---|
| 9a(1). Speech Therapy | | | | |
| 9a(2). Occupational Therapy | | | | |
| 9a(3). Physical Therapy | | | | |
| 9a(4). Psychological Counseling | | | | |
| 9a(5). Intensive Behavioral Intervention *(Includes ABA)* | | | | |
| 9a(6). Other *(Specify)* | | | | |

**10. COMMUNICATION** *(Select one)*

☐ VERBAL

☐ NON-VERBAL *(Uses:)*

- ☐ Signing
- ☐ Picture Exchange Communication System (PECS)
- ☐ Communication Device
- ☐ Combination

**11. OTHER INTERVENTIONS / THERAPIES USED BY THE FAMILY**
*(Specify alternate or complimentary therapies)*

**12. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR**
*(If "Yes," provide details)* ☐ YES ☐ NO

**PROVIDER INFORMATION**

| 13a. PROVIDER PRINTED NAME OR STAMP | 13b. SIGNATURE | 13c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

Prescribed by: DoDI 1315.19

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY** *(Continued)*: **To be completed by a Qualified Medical Provider**

**PART B - REQUIRED MEDICAL SPECIALTIES**

**. HEALTH CARE REQUIRED** *(Educational services should be noted on a DD Form 2792-1)*
INDICATE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY *(Twice per year)* Q - QUARTERLY M - MONTHLY BI - BIMONTHLY W - WEEKLY

| | (1) CARE PROVIDER *(Select as Appropriate)* | (2) FREQUENCY *(See Above)* | | (1) CARE PROVIDER *(Select as Appropriate)* | (2) FREQUENCY *(See Above)* |
|---|---|---|---|---|---|
| a | ☐ ALLERGIST / IMMUNOLOGIST | | ii | ☐ OCCUPATIONAL THERAPIST - PEDIATRIC | |
| b | ☐ APPLIED BEHAVIOR ANALYST | | jj | ☐ OPHTHALMOLOGIST - ADULT | |
| c | ☐ AUDIOLOGIST | | kk | ☐ OPHTHALMOLOGIST - PEDIATRIC | |
| d | ☐ BEHAVIOR ANALYST | | ll | ☐ ORAL SURGEON | |
| e | ☐ CARDIAC / THORACIC SURGEON | | mm | ☐ ORTHOPEDIC SURGEON - ADULT | |
| f | ☐ CARDIOLOGIST - ADULT | | nn | ☐ ORTHOPEDIC SURGEON - PEDIATRIC | |
| g | ☐ CARDIOLOGIST - PEDIATRIC | | oo | ☐ OTORHINOLARYNGOLOGIST | |
| h | ☐ CLEFT PALATE TEAM - PEDIATRIC | | pp | ☐ PAIN CLINIC | |
| i | ☐ COUNSELOR *(Specify)* | | qq | ☐ PEDIATRIC NURSE PRACTITIONER | |
| j | ☐ DERMATOLOGIST | | rr | ☐ PEDIATRICIAN | |
| k | ☐ DEVELOPMENTAL PEDIATRICIAN | | ss | ☐ PEDIATRIC SURGEON | |
| l | ☐ DIALYSIS TEAM | | tt | ☐ PHYSIATRIST *(Physical Rehabilitation)* | |
| m | ☐ DIETARY / NUTRITION SPECIALIST | | uu | ☐ PHYSICAL THERAPIST | |
| n | ☐ ENDOCRINOLOGIST - ADULT | | vv | ☐ PLASTIC SURGEON - ADULT | |
| o | ☐ ENDOCRINOLOGIST - PEDIATRIC | | ww | ☐ PLASTIC SURGEON - PEDIATRIC | |
| p | ☐ FAMILY PRACTITIONER | | xx | ☐ PODIATRIST | |
| q | ☐ GASTROENTEROLOGIST - ADULT | | yy | ☐ PSYCHIATRIST - ADULT | |
| r | ☐ GASTROENTEROLOGIST - PEDIATRIC | | zz | ☐ PSYCHIATRIST - PEDIATRIC | |
| s | ☐ GENERAL SURGEON | | aaa | ☐ PSYCHIATRIST NURSE PRACTITIONER | |
| t | ☐ GENETICS | | bbb | ☐ PSYCHOLOGIST - ADULT | |
| u | ☐ GYNECOLOGIST | | ccc | ☐ PSYCHOLOGIST - PEDIATRIC | |
| v | ☐ GYNECOLOGIST / ONCOLOGIST | | ddd | ☐ PULMONOLOGIST - ADULT | |
| w | ☐ HEMATOLOGIST / ONCOLOGIST - ADULT | | eee | ☐ PULMONOLOGIST - PEDIATRIC | |
| x | ☐ HEMATOLOGIST / ONCOLOGIST - PEDIATRIC | | fff | ☐ RADIATION ONCOLOGIST | |
| y | ☐ INFECTIOUS DISEASE | | ggg | ☐ RESPIRATORY THERAPIST | |
| z | ☐ INTERNIST | | hhh | ☐ RHEUMATOLOGIST - ADULT | |
| aa | ☐ NEPHROLOGIST - ADULT | | iii | ☐ RHEUMATOLOGIST - PEDIATRIC | |
| bb | ☐ NEPHROLOGIST - PEDIATRIC | | jjj | ☐ SOCIAL WORKER | |
| cc | ☐ NEUROLOGIST - ADULT | | kkk | ☐ SPEECH AND LANGUAGE PATHOLOGIST | |
| dd | ☐ NEUROLOGIST - PEDIATRIC | | lll | ☐ TRANSPLANT TEAM | |
| ee | ☐ NEUROPSYCHIATRIST | | mmm | ☐ UROLOGIST - ADULT | |
| ff | ☐ NEUROPSYCHOLOGIST | | nnn | ☐ UROLOGIST - PEDIATRIC | |
| gg | ☐ NEUROSURGEON | | ooo | ☐ VASCULAR SURGEON | |
| hh | ☐ OCCUPATIONAL THERAPIST - ADULT | | ppp | ☐ OTHER *(Specify)* | |

**PROVIDER INFORMATION**

| 15a. PROVIDER PRINTED NAME OR STAMP | 15b. SIGNATURE | 15c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

| FAMILY MEMBER / PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME *(Last, First, Middle Initial)* | SPONSOR DoD ID # |
|---|---|---|
| | | |

**MEDICAL SUMMARY *(Continued)*: To be completed by a Qualified Medical Provider**

**PART B - REQUIRED MEDICAL SPECIALTIES *(Continued)***

**16. ARTIFICIAL OPENINGS / PROSTHETICS *(Select all that apply)***

☐ YES IF "YES": ☐ GASTROSTOMY ☐ COLOSTOMY ☐ OTHER UNSPECIFIED OPENING *(Specify)*

☐ NO ☐ TRACHEOSTOMY ☐ ILEOSTOMY

☐ CSF SHUNT ☐ OTHER UNSPECIFIED PROSTHETICS *(Specify)*

**17. MEDICALLY INDICATED *(As indicated in diagnostic information)* ENVIRONMENTAL / ARCHITECTURAL CONSIDERATIONS**

☐ LIMITED STEPS *(If selected, please explain below)* ☐ AIR CONDITIONING

☐ COMPLETE WHEELCHAIR ACCESSIBILITY ☐ TEMPERATURE CONTROL ☐ POLLEN CONTROL

☐ SINGLE STORY / LEVEL HOUSE ☐ HEPA FILTER ☐ AIR FILTERING

☐ CARPET PROHIBITED ☐ OTHER *(Specify below)*

*(Specify and provide justifications for environmental / architectural considerations)*:

**18. MEDICALLY NECESSARY ADAPTIVE EQUIPMENT / SPECIAL MEDICAL EQUIPMENT *(Identified in diagnostic information. If selected, describe)***

| 18a. TYPE OF EQUIPMENT *(Select as applicable)* | 18b. DESCRIPTION | 18a. TYPE OF EQUIPMENT *(Select as applicable)* | 18b. DESCRIPTION |
|---|---|---|---|
| ☐ APNEA HOME MONITOR | | ☐ HOME VENTILATOR *(Include make and model under "Description")* | |
| ☐ COCHLEAR IMPLANT *(Include make and model under "Description")* | | ☐ INSULIN PUMP *(Include make and model under "Description")* | |
| ☐ CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY | | ☐ INTERNAL DEFIBRILLATOR *(Include make and model under "Description")* | |
| ☐ FEEDING PUMP *(Include make and model under "Description")* | | ☐ PACEMAKER *(Include make and model under "Description")* | |
| ☐ HEARING AIDS *(Include make and model under "Description")* | | ☐ SPLINTS, BRACES, ORTHOTICS | |
| ☐ HOME DIALYSIS MACHINE | | ☐ SUCTION MACHINE | |
| ☐ HOME NEBULIZER | | ☐ WHEELCHAIR | |
| ☐ HOME OXYGEN THERAPY | | ☐ OTHER *(Specify)* | |

**19. IDENTIFY ANY LIMITATIONS FOR ACTIVITIES OF DAILY LIVING AND ANY TRAVEL LIMITATIONS *(Please explain)***

**PROVIDER INFORMATION**

| 20a. PROVIDER PRINTED NAME OR STAMP | 20b. SIGNATURE | 20c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

# Provider Instructions for Completing the DD Form 2792-1

This document guides early intervention or school staff through the completion of the DD Form 2792-1, Early Intervention / Special Education Summary.

## Purpose of the DD Form 2792-1:

Families are **required** to complete a DD Form 2792-1 for two different reasons:

1. Document **early intervention / special education needs for potential enrollment into the Exceptional Family Member Program (EFMP)**, which supports military families with special medical and / or educational needs.
2. Document the **early intervention / special education needs of a family member during Family Member Travel Screening (FMTS)**. This information will be coordinated with the Department of Defense Education Activity (DoDEA) and the gaining FMTS Office to determine the availability of early intervention / education services at the projected duty location.

## Who completes the DD Form 2792-1:

- ✓ The **Sponsor, Spouse, Legal Guardian, or Student who has reached Age of Majority** completes the demographics requested on the form.
- ✓ An early intervention (EI) or school representative.

## What to do after you complete the form:

- ✓ Return the form back to the family, who will route the form accordingly.

## Additional Tips for Completing the Form:

- ❖ **Pages 2-3** are completed by the **Sponsor, Spouse, Legal Guardian, or Student who has reached Age of Majority** and **Administrative Staff**.
- ❖ **Page 3** is also completed by school or early intervention staff.
- ❖ The family must submit the DD Form 2792-1 with a complete, up-to-date Individualized Education Program (IEP) or Individual Family Service Plan (IFSP), if applicable.
- ❖ Public school personnel complete the DD Form 2792-1 for **all** families that receive services through the public school, even if the families attend non-public school (e.g. homeschool, charter schools, private schools).
- ❖ School personnel complete the DD Form 2792-1 for **all** families that are enrolled in the school, even if the families do not receive early intervention or special education services.
- ❖ If a child is under five years of age, is not enrolled in school, a home school program, or engaged with an Early Intervention Services program, and does not have any identified needs, the parent or guardian can complete and sign page 2 and return it to the requesting office.
    - o The completion of page 3 is not required in this case.

# EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

OMB No. 0704-0411
OMB APPROVAL EXPIRES 20230930



## PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 136, 20 U.S.C. 927, DoDI 1315.19, DoDI 1342.12.

**PRINCIPAL PURPOSE(S):** Information will be used by DoD personnel to evaluate and document the early intervention/special education needs of family members. This information will enable: (1) sponsors to enroll into the Exceptional Family Member Program (EFMP), (2) military assignment personnel to match the early intervention/special education needs of family members against the availability of early intervention/special education services through the Family Member Travel Screening (FMTS) process, (3) EFMP Family Support staff to offer information on community support services, and (4) civilian personnel offices to advise civilian employees about the availability of education services to meet the early intervention/special education needs of their family members. The personally identifiable information collected on this form is covered by a number of system of records notices pertaining to Official Military Personnel Files, Exceptional Family Member or Special Needs files, Civilian Personnel Files, and DoD Education Activity files.

The applicable SORNs and routine uses that apply can be found at: Air Force: F036 AF PC C, Military Personnel Records System at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569879/f036-af-pc-c/; F044 AF SG U, Special Needs and Educational and Developmental Intervention Services at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569879/f044-af-sg-u/; Army: A0600-8-104b AHRC, Official Military Personnel Record at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570054/a0600-8-104b-ahrc/; A0608b CFSC, Personnel Affairs Army Community Service Assistance Files at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570084/a0608b-cfsc/;
DHA: EDHA 07, Military Health Information System at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/;
OSD/JS: DMDC 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/627518/dmdc-02-dod/;
DPR 34 DoD, Defense Civilian Personnel Data System at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570697/dpr-34-dod/;
EDHA 16 DoD, Special Needs Program Management Information System (SNPMIS) Records at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570679/edha-16-dod/;
DoDEA 29, DoDEA Non-DoD Schools Program at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570576/dodea-29/;
DoDEA 26, Department of Defense Education Activity Educational Records at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570573/dodea-26/;
Navy and Marine Corps: "M01070-6, Marine Corps Official Military Personnel Files at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570626/m01070-6/;
M01754-6, Exceptional Family Member Program Records at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/;
N01070-3, Navy Military Personnel Records System at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570310/n01070-3/;
N01301-2, On-Line Distribution Information System (ODIS) at https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570320/n01301-2/

**DISCLOSURE:** Voluntary for civilian employees and applicants for civilian employment. 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. The DoD Identification (DoD ID) number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System and Service personnel offices to work together to ensure any early intervention/special education needs of your dependent can be met at your next duty assignment. Dependent early intervention/special education needs are annotated in the official military personnel files which are retrieved by name and DoD ID number.

## INSTRUCTIONS FOR COMPLETING DD FORM 2792-1, EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

The DD Form 2792-1 is completed to identify a family member with early intervention / special education needs.

### DEMOGRAPHICS

**Items 1 - 7.** To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.

**Item 1.** Request (X one):

- Exceptional Family Member Program (EFMP) Enrollment or Update - first enrollment application for the family member or to update a previous evaluation for the family member
- Government Sponsored Travel
- Change in EFMP Status

**Items 2.a. - h.** Child / Student Information. Self-explanatory.

**Items 3.a. - h.** Sponsor Information. Self-explanatory.

**Item 3.i.** Child / student enrolled in Defense Enrollment Eligibility Reporting System (DEERS) under another sponsor. Self-Explanatory.

**Items 4a. - d.** Self-explanatory.

**Item 5.** Completed for children age birth to 3.

**Items 6.a. - c.** Completed for children ages 3 to 21 only. Children who are ages 3 to 5 should have the DD Form 2792-1 completed at the school the child would normally attend for kindergarten. High school graduates, students who have passed the G.E.D., and college students are not required to complete the DD Form 2792-1. NOTE: For 6.c., students that are home-schooled are eligible to receive some form of special education services in the public school setting. Therefore they may have a private school service plan. Include a copy of the service plan as applicable.

**Items 7.a. - d.** Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority and completed the form. Self-explanatory.

**Items 8.a. - f.** Administrative Review. Completed by EFMP Office or Family Member Travel Screening (FMTS) Office responsible for enrollment or screening. NOTE: For 8.c., if child is entered into DEERS under a DoD ID number other than what is provided in 8.a. and 8.b., list the additional ID in 8.c.

### EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY.

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for family member travel screening or EFMP enrollment.**

**Items 9.a. - d.** Sponsor Information. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority is REQUIRED to authorize the school to release information.

**Items 10.a. - d.** Child / Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

**Items 11.a. - e.** Early Intervention Summary (EIS) Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

**Items 12.a. - f.** School Information. Completed by school personnel at the school the child attends. Mark (X) Yes or No for each item. Include additional information as noted.

**Item 13.** Completed by school personnel. Mark (X) eligibility category. Mark only one.

**Item 14.** Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

**Items 15.a - c.** Completed by EIS and school personnel. Self-explanatory.

**Items 16.a - j.** Completed by EIS provider / school official information completing the form. Self-explanatory.

**NOTE:** If child is under 5 years of age, is not enrolled in school, a home school program, or engaged with an Early Intervention Services program, and does not have any identified needs, the parents or guardians can fill out and sign page 2 of the DD Form 2792-1 and return it to the requesting office. The completion of Page 3 is not required in this case.

## EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

*(Page 2. Items 1 - 7 to be completed by sponsor, parent, or legal guardian. Read Privacy Act Statement and Instructions before completing the form.)*

## DEMOGRAPHICS

**1. REQUEST** *(Select One)*

☐ EFMP Enrollment or Update
☐ Request Change in EFMP Status
☐ Request for Government Sponsored Travel
☐ No longer requires IEP / IFSP
☐ Divorce / change in custody*
☐ No longer qualifies as a dependent
☐ Family member deceased
*(*Provide documentation to change status)*

**2. CHILD / STUDENT INFORMATION** *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.)*

| 2a. CHILD / STUDENT NAME *(Last, First, Middle Initial)* | 2b. SPONSOR NAME *(Last, First, Middle Initial)* | 2c. CHILD / STUDENT CURRENT MAILING ADDRESS *(Street, Apartment Number, City, State, ZIP Code, APO / FPO)* |
|---|---|---|
| 2d. FAMILY MEMBER PREFIX | 2e. CHILD / STUDENT DATE OF BIRTH *(YYYYMMDD)* | 2f. CHILD / STUDENT GENDER *(Select one)* ☐ Male ☐ Female |
| 2g. FAMILY HOME E-MAIL ADDRESS | 2h. HOME TELEPHONE NUMBER *(Include Country Code / Area Code)* | |

| 3a. SPONSOR RANK OR GRADE | 3b. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT *(Include City, State, Country)* | |
|---|---|---|
| 3c. SPONSOR'S OFFICIAL E-MAIL ADDRESS | 3d. DUTY TELEPHONE NUMBER *(Include Country Code / Area Code)* | 3e. MOBILE NUMBER *(Include Country Code / Area Code)* |

**3f. STATUS** *(Select One)*
☐ Regular Active Service Member ☐ Active Reserve ☐ Active Guard
☐ Reserves ☐ National Guard ☐ Civilian

**3g. BRANCH OF SERVICE** *(Military Only)*
☐ Army ☐ Navy ☐ Air Force
☐ Marine Corps ☐ Coast Guard

**3h. DOES CHILD RESIDE WITH SPONSOR?** *(Select One. If No, Explain.)*
☐ Yes ☐ No

**3i. IS THE CHILD / STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE?** *(Select One. If Yes, provide name of sponsor)*
☐ Yes ☐ No

**4a. ARE BOTH SPOUSES ON ACTIVE DUTY?** *(Military Only. Select One. If Yes, Complete 4b.- 4d. below)* ☐ Yes ☐ No

| 4b. ACTIVE DUTY SPOUSE'S NAME *(Last, First, Middle Initial)* | 4c. BRANCH OF SERVICE | 4d. RANK / RATE |
|---|---|---|
| | | |

**5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY!**
☐ Yes ☐ No Is your child being evaluated for, or eligible for early intervention services on an Individualized Family Service Plan (IFSP)?
*(Select one. If No, sign Item 7 and return to the requesting office. If Yes, have early intervention professional complete page 3.)*

**6. EDUCATION SERVICES FOR DEPENDENTS 3 YEARS AND OLDER:**

6a. Is your child being home-schooled full-time or part-time? *(Select one)* ☐ Yes, Part-Time ☐ Yes, Full-Time ☐ No *(If Yes, complete 6a(1) and 6a(2))*

6a(1). When did you start home-schooling? *(YYYYMMDD)* _____

6a(2). Name of home school program/title of courses: _____

6b. Is your child being evaluated for, or receiving special education services on an IEP? ☐ Yes ☐ No
If Yes, have the child's school (or primary care provider if school is not in session) complete page 3.

6c. List any special education-related services received in the last 3 years: *(include a copy of the service plan as applicable)* _____

**7. RELEASE OF INFORMATION** *(To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority)* I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to appropriate personnel of the Department of Defense. This information will be used to evaluate and document my child / student's needs for educational services for the purpose of assignment coordination, EFMP enrollment, or eligibility for other educationally related benefits.

| 7a. SIGNATURE | 7b. PRINTED NAME | 7c. RELATIONSHIP TO CHILD / STUDENT | 7d. DATE *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

**8. ADMINISTRATIVE REVIEW** *(Completed after review of entire form by local MTF or office receiving form.)*

| 8a. SPONSOR DoD ID # | 8b. SPOUSE DoD ID # *(If dual military)* | 8c. DoD ID # USED IN DEERS *(If different from sponsor's)* | 8f. STAMP |
|---|---|---|---|
| 8d. MTF OR OFFICE RECEIVING COMPLETED FORM | | 8e. DATE *(YYYYMMDD)* | |

## EARLY INTERVENTION / SPECIAL EDUCATION SUMMARY

**NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:** It is important to the military and to the family that the service member be assigned to a location that can meet the child's educational needs. Your support in completing this form is appreciated. *(If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)*

**9. RELEASE OF INFORMATION** (To be completed by sponsor, spouse, legal guardian, or student who has reached the age of majority.) I hereby authorize the release of information on the DD Form 2792-1 and the attached reports to personnel of the Military Departments. This information will be used to evaluate and document my child / student's needs for educational services for the purpose of assignment coordination, EFMP enrollment or eligibility for other educationally related benefits.

| 9a. PRINTED NAME | 9b. SIGNATURE | 9c. RELATIONSHIP TO CHILD / STUDENT | 9d. DATE *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

**10. CHILD / STUDENT INFORMATION** *(To be completed by sponsor, spouse, or legal guardian)*

| 10a. NAME OF CHILD / STUDENT *(Last, First, Middle Initial)* | 10b. CURRENT GRADE LEVEL *(If school age)* | 10c. DATE OF BIRTH *(YYYYMMDD)* | 10d. GENDER *(Select one)* |
|---|---|---|---|
| | | | ☐ Male ☐ Female |

**11. EARLY INTERVENTION SERVICES (EIS) - FOR CHILDREN UNDER 3 YEARS OF AGE** *(To be completed by EIS representative)*

YES NO

☐ ☐ 11a. Is the child currently being evaluated for early intervention services?

☐ ☐ 11b. Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? *(If Yes, please attach current IFSP).* Date of next annual review *(YYYYMMDD)* _____

☐ ☐ 11c. Has the child been found eligible but the family declined IFSP services?

11d. Basis for eligibility. ☐ Developmental Delay ☐ Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay

11e. Is there an identified disability? *(If known, please specify)*

**12. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21** *(To be completed by school representative - answer all questions)*

YES NO

☐ ☐ 12a. Is this student currently being evaluated for special education services?

☐ ☐ 12b. Has the child been found eligible for special education services? *(If Yes, complete Item 13.)*

☐ ☐ 12c. If your school determined the student eligible for special education services within the past 3 years, did the parent decline special education services? *(If Yes, complete eligibility information in Item 13 and proceed to Item 16)*

☐ ☐ 12d. Does this child / student receive special education services under a current Individualized Education Program (IEP)? Date of next annual review *(YYYYMMDD)* _____ *(If Yes, complete Items 13 and following and attach a copy of the current IEP.)*

☐ ☐ 12e. Were IEP services terminated by the IEP team due to ineligibility within the last 2 years? Date of IEP termination *(YYYYMMDD)* _____

☐ ☐ 12f. Was the IEP terminated at the request of the parents within the last year (parents withdrew student from special education)? *(If Yes, complete Items 13 and following).* Date of IEP termination *(YYYYMMDD)* _____

**13. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE** *(Select only one)* ☐ N/A

| | | |
|---|---|---|
| ☐ Autism Spectrum Disorder | ☐ Communication Impaired | ☐ Behavioral / Conduct Disorder |
| ☐ Deaf | ☐ Articulation | ☐ Intellectual Disability |
| ☐ Blind | ☐ Dysfluency | ☐ Mild |
| ☐ Deaf / Blind | ☐ Voice | ☐ Moderate |
| ☐ Visually Impaired | ☐ Language / Phonology | ☐ Severe / Profound |
| ☐ Traumatic Brain Injury | ☐ Developmental Delay | ☐ Other Health Impaired *(Specify)* |
| ☐ Hearing Impaired | ☐ Specific Learning Disability | |
| ☐ Orthopedically Impaired | ☐ Emotionally Impaired | |

**14. RELATED SERVICES ON IEP** *(Select boxes next to related services and indicate total number of minutes or hours that services are provided.)* ☐ N/A

SERVICE: M = Minutes, H = Hours per W = Week, M = Month (Example: 20 M per W)

| | | | | |
|---|---|---|---|---|
| ☐ Counseling | | | per | |
| ☐ Occupational Therapy | | | per | |
| ☐ Physical Therapy | | | per | |
| ☐ Speech Therapy | | | per | |
| ☐ Intensive Behavioral Intervention (such as ABA) | | | per | |

☐ Special Transportation *(Describe)* _____

☐ Other *(Describe)* _____

**15. BEHAVIOR / COMMUNICATION** *(Select all that apply and specify in comments section)*

YES NO

☐ ☐ 15a. Child exhibits high risk or dangerous behavior

☐ ☐ 15b. Child is verbal *(If No, answer 15b(1)-15b(4) The student uses:)*

☐ ☐ 15b(1). Signing

☐ ☐ 15b(2). Picture Exchange Communication System (PECS)

☐ ☐ 15b(3). Communication Device

☐ ☐ 15b(4). Other

**15c. COMMENTS**

**16. PROVIDER / SCHOOL INFORMATION**

| 16a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL | 16b. SCHOOL DISTRICT | |
|---|---|---|
| | | |
| **16c. CITY, STATE, COUNTRY** | **16d. TELEPHONE NUMBER** *(Include Country Code / Area code)* | **16e. FAX NUMBER** *(Include Country Code / Area Code)* |
| | | |

| 16f. E-MAIL ADDRESS | 16g. NAME OF INDIVIDUAL COMPLETING THIS SECTION | |
|---|---|---|
| | | |
| **16h. SIGNATURE** | **16i. TITLE** | **16j. DATE** *(YYYYMMDD)* |
| | | |