FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN

FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS *(X one)*

- ☐ FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER
- ☐ REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)
- ☐ UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER
- ☐ OTHER *(e.g., Extended Care Health Option Eligibility)*:
- ☐ QUALIFIES FOR CHANGE IN EFMP STATUS:
  - ☐ FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION
  - ☐ FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*
  - ☐ FAMILY MEMBER DECEASED*
  - ☐ DIVORCE/CHANGE IN CUSTODY*

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

8. SUMMARY *(X one)*

☐ ONGOING MEDICAL CONDITIONS ☐ TEMPORARY MEDICAL CONDITIONS ☐ BOTH

9.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? *(X one)*

☐ YES ☐ NO *(If Yes, complete 9.b. and c.)*

b. LOCATION OF CASE MANAGER *(X)* ☐ MTF ☐ TRICARE ☐ CIVILIAN

c. CASE MANAGER CONTACT INFORMATION

(1) NAME *(Last, First, Middle Initial)*	(2) TELEPHONE NUMBER *(Include Area Code/Country Code)*	(3) ADDRESS *(Include ZIP Code or APO/FPO)*

10. REQUIRED ADDENDA. Complete Item 1 on Addendum 1 (page 8) and item 1 on Addendum 2 (page 9) and item 1 on Addendum 3 (page 11) AND X box below if:

- ☐ ASTHMA ADDENDUM 1 IS REQUIRED AND ☐ ATTACHED
- ☐ MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND ☐ ATTACHED
- ☐ AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND ☐ ATTACHED

11. SPECIAL ASSIGNMENT CONSIDERATIONS *(X all that apply)*

- ☐ a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION *(If marked, DD Form 2792-1 must be completed)*
- ☐ b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS
- ☐ c. RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ d. RECEIVING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) FROM THE SOCIAL SECURITY ADMINISTRATION
- ☐ e. RECEIVING STATE MEDICAID OR MEDICARE WAIVER SERVICES
- ☐ f. RECEIVING VOCATIONAL REHABILITATION SERVICES
- ☐ g. RECEIVING SPECIAL CHILD CARE ACCOMMODATIONS
- ☐ h. OTHER *(Specify)*

12.a. ARE THERE OTHER EFMP MEMBERS IN THE FAMILY *(Not including this family member)*?

☐ YES ☐ NO b. IF YES, HOW MANY? _____

13. ADMINISTRATIVE CERTIFICATION

a. PRINTED NAME *(Last, First, Middle Initial)*	b. TITLE	c. SIGNATURE	d. DATE *(YYYYMMDD)*

e. FACILITY ADDRESS *(Include ZIP Code or APO/FPO)*	f. TELEPHONE NUMBER *(Include area code/Country Code)*	g. OFFICIAL STAMP