| FAMILY MEMBER/PATIENT NAME *(Last, First, Middle Initial)* | SPONSOR NAME | SPONSOR SSN *(Last four)* |
|---|---|---|
| | | |

## FOR ADMINISTRATIVE USE ONLY

**8. REQUIRED ACTIONS** *(X 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 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.)*

**9. REQUIRED ADDENDA.**

Verify required addendum is attached and has been signed *(X each that applies)*. Do not submit a blank addendum for EFMP review.

- ☐ **Asthma Addendum 1 is required and** ☐ **Attached.**
- ☐ **Mental Health Summary Addendum 2 is required and** ☐ **Attached.**
- ☐ **Autism Spectrum Disorder/Developmental Delay (AS/DD) Addendum 3 is required and** ☐ **Attached.**

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

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

## CERTIFICATION

**11. CERTIFICATION. DO NOT CERTIFY BEFORE THE MEDICAL PROVIDER COMPLETES THE ENTIRE FORM AND ADDENDA.**

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:**

| a. PRINTED NAME | b. SIGNATURE | c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

**12. ADMINISTRATIVE CERTIFICATION**

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

| a. PRINTED NAME | b. SIGNATURE | c. DATE *(YYYYMMDD)* |
|---|---|---|
| | | |

**12. ADMINISTRATIVE CERTIFICATION**