

DATE:

**ARMY COMMUNITY SERVICE  
EXCEPTIONAL FAMILY MEMBER SCREENING INFORMATION**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 5U.S.C Section 301 and 10 U.S.C Section 3013.

**PRINCIPAL PURPOSE(S):** To detect and refer family members with emotional, physical, developmental, or intellectual problems for enrollment in the Exceptional Family Member Program. Enrollment in the program is mandatory.

**ROUTINE USES:** Information may be disclosed to bonafide federal, state, or local social service or welfare organizations.

**DISCLOSURE:** Disclosure of information is voluntary; however, failure to provide information may result in family members not receiving necessary information and assistance.

|      |            |            |
|------|------------|------------|
| NAME | RANK       | SSN        |
| UNIT | WORK PHONE | HOME PHONE |

1. Do you have a family member you believe has a special need, birth defect, physical/mental impairment or illness, or disability?

YES     NO (if NO, do NOT continue)

Name of Family Member \_\_\_\_\_ Age \_\_\_\_

2. Relationship of affected dependent family member(s):

Spouse     Son     Daughter     Mother     Father    \_\_\_\_\_ Other

3. Which of the following birth defect(s), impairment(s), illness(es) or disability(ies) affect your family member(s). (Check all that apply)

|   |  |   |
|---|--|---|
| <input type="checkbox"/> Mental Retardation                 | <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Multiple Handicaps |
| <input type="checkbox"/> Speech and or Language impairments | <input type="checkbox"/> Hearing Impairments   | <input type="checkbox"/> Visual Handicaps   |
| <input type="checkbox"/> Emotional Illness/Disability       | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> ADD/ADHD           |

Please write name of disability \_\_\_\_\_

**CONSENT:** I hereby authorize any physician, hospital, medical clinic, or educational institution to release pertinent information to the Exceptional Family Member Program staff. Only information which may have a bearing on the benefits and/or services provided by the Exceptional Family Member Program will be collected.

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|

EFMP Manager Remarks