AIR FORCE SPECIAL NEEDS SCREENER

(Completed by all Sponsors with Family Members)

(This Form is Subject the the Privacy Act of 1974 - USE BLANKET PAS - DD FORM 2005)

AUTHORITY: 10 U.S.C. 55. 10 U.S.C. 8013 and E.O. 9397 (SSN) as amended.

PURPOSE(S): Used to document, plan, and coordinate the health care of family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data.

ROUTINE USE: Used to accumulate information for determining family member special needs.

DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of family member's suitability for relocation at government expense or delay issuance of PCS orders.

TO: SPECIAL NEEDS COORDINATOR AND AIR FORCE PERSONNEL CENTER (AFPC)

FROM: Air Force Family Member Special Needs Identification Screener

The Air Force makes an effort to ensure specialized medical and educational services are available for all military family members. In order to help us do this, we need to know if any special medical and/or educational needs exist for your family members. You are required to complete this form as part of your relocation processing, if you have family members, whether they are living with you or not.

SPONSOR'S INFORMATION

Sponsor's Name *(Last, First, MI)*	Rank	*(enter last 4 digits only)* Social Security Number *(SSN)* (Last 4 digits only)
Current Unit and Duty Station	Duty Telephone Number	Telephone Number
Projected Installation If Relocating	Projected Departure Date	

SPONSOR'S FAMILY INFORMATION

Please read and answer all questions. Indicate (X) the appropriate box. **Thank you.**

1. Are your currently enrolled in any Service's Exceptional Family Member Program (EFMP)? Yes ☐ No ☐ **If yes, stop here.**
2. Do any of your children receive Special Education Services? Yes ☐ No ☐
3. Do any of your children receive Early Intervention Services? Yes ☐ No ☐
4. Do any of your family members receive speech therapy, occupational therapy, physical therapy, or counseling services? Yes ☐ No ☐
5. Has any dependent member of your family been hospitalized for the same condition more than once? Yes ☐ No ☐
6. Has any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than once times in the last year? Yes ☐ No ☐
7. Do any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist, other than a PCM (such as cardiology, internist, psychology, neurology, Yes ☐ No ☐
8. Do any of your dependent family members have reactive airway disease or asthma? Yes ☐ No ☐
9. Do any of your family members require specialized equipment or modified housing? Yes ☐ No ☐

If YES to any questions numbered 2 - 8, please contact the Exceptional Family Member Program (EFMP-M) Office at the Military Treatment Facility for assistance prior to pursuing any further relocation actions.

I certify that this information is complete and accurate to the best of my knowledge. I understand that insufficient and/or inaccurate information may affect family member travel at government expense. I understand that making a knowing and willful false official statement can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

Sponsor's Signature _____ Date _____

AF FORM 4380, 20150806