

PRIVACY ACT STATEMENT

Authority: Title 10, USC, Sections 3010, 3012, and 5051; Title 5, USC, Section 301; and EO 9397 (SSN).
 Principal Purpose: To make assignment decisions, evaluate family member travel to overseas commands and design family housing.
 Routine Uses: General disclosures permitted by the Privacy Act and the Army's systems of records notices apply.
 Disclosure: Disclosure of information is voluntary. If the information is not provided, commanders will not be aware of family member travel and housing requests, and will result in no government travel and housing for family members.

PART A - PERSONNEL AND ASSIGNMENT MANAGEMENT DATA (To be Completed by Losing MPD/PSC)

1. TO MPD Yongsan APO AP 96205		2. FROM Losing Unit/Address	
3. NAME (Last, First, Middle) Writing must be legible		4. SSN SSN	5. GRADE E 6
6A. CURRENT ORGANIZATION 396 T.S. FSG A		6B. REASSIGNED TO (M/MSCA/PO/Country) Korea	
6C. TELEPHONE NO. (Include Area Code)	7A. RSG AUTH	7C. PERS CON NO.	7D. REPORT DATE (YYYYMMDD) 20120110
6D. AND EMAIL ADDRESS			

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

PART B - HOUSING AND FAMILY TRAVEL DATA

10. I do <input type="checkbox"/> do not <input checked="" type="checkbox"/>					
11. I am a sole parent <input type="checkbox"/>					
12. Application for Family Member					
a. <input checked="" type="checkbox"/>	I desire concurrent				
b. <input type="checkbox"/>	I desire concurrent				
13. Family Members Who Will Travel to Next Permanent Duty Station (If more space is needed, continue on a separate sheet.)					
A. NAME (Last, First, MI)		B. RELATIONSHIP	C. SEX	D. DATE OF BIRTH (YYYYMMDD)	E. CITIZENSHIP
List all authorized dependents		Spouse	F	19720317	
		Son	M	19990303	
14. ANY RELATIVE IN GAINING OVERSEAS AREA WHERE FAMILY MEMBERS MAY RESIDE PENDING AVAILABILITY OF HOUSING AT OR NEAR DUTY STATION (Include name, relationship, address and phone number).					
15A. ADDRESS WHERE MY FAMILY IS CURRENTLY LOCATED			15B. ADDRESS WHERE MY FAMILY MAY BE CONTACTED WHILE ON LEAVE		
16A. TELEPHONE NO. (Include Area Code)			16B. TELEPHONE NO. (Include Area Code)		
17. The soldier is administratively qualified and available for assignment. Control sheets/forms prescribed by the regulation (or their equivalent) have been completed. A request for deletion or deferment is <input type="checkbox"/> anticipated <input type="checkbox"/> not anticipated.					
17A. ASSIGNMENT WORK CENTER EMAIL ADDRESS (Army Specific)			17D. DATE (YYYYMMDD) 20110921		

Ensure you have the proper signatures



Winn ACH
 EFMP Review
 Ft. Stewart/
 HAAF
 GA
 EFMP
 2011/09/21

Don't forget to sign

FAMILY MEMBER DEPLOYMENT SCREENING SHEET

For use of this form, see AR 600-75, the proponent agency is OACSIM



DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, USC Section 3013.
PRINCIPAL PURPOSE: Personnel support.
ROUTINE USES: To validate family member deployment screening, and to provide gaining command with data to assist in making an assignment decision.
DISCLOSURE: The provision of requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the soldier.

PART A - SOLDIER/FAMILY MEMBER DATA

1. NAME OF SOLDIER (Last, first, MI)	2. SOCIAL SECURITY NUMBER	3a. RANK SSG	3b. MOS/BRANCH 88M
4a. HOME ADDRESS	4a. DUTY ADDRESS	5. DATE OF EDAS CYCLE OR RFO (OFF) DATE	
4b. HOME PHONE NO. (include Area Code)	5b. DUTY PHONE NO. & DSN		

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

6. AUTHENTICATION

a. MILITARY PERSONNEL DIVISION/PERSONNEL SERVICE COMPANY REPRESENTATIVE'S NAME	c. RANK (Grade)	d. SIGNATURE
MPD or S1 must sign		

PART B - FAMILY MEMBER SCREENING RESULTS

9. NAME	EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT (Check one)		
	a. NOT WARRANTED	b. CONSIDERATION WARRANTED (Date sent for Coding)	c. SUBSTANTIAL CHANGE SINCE ENROLLMENT
			NO YES DATE SENT FOR CODING

List all authorized dependents

/	/	/	/	/	/	/	/	/	/
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10. ARMY MEDICAL TREATMENT FACILITY (AMTF) EPMP MEDICAL PRACTITIONER COMPLETING THIS FORM

a. PRINTED NAME OF MEDICAL PRACTITIONER	b. SIGNATURE	c. DATE (YYYYMMDD)
		22/09/21
d. ADDRESS (12) (Include DSN)	e. PHONE NUMBER (12) (Include DSN)	
	DSN: 475-8505/6970 FAX: 435-5050/475-5050	

Get proper signature

11. ARMY MTF EPMP PHYSICIAN'S AUTHENTICATION (To be signed when a medical practitioner other than a physician completes this form.)

a. TYPED OR PRINTED NAME OF PHYSICIAN MARK C. KRUEGER, MD EPMP PHYSICIAN	b. TITLE	c. RANK
d. SIGNATURE	e. DATE (YYYYMMDD)	
	22/09/21	

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
Mar 31, 2014

The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Service, Executive Service Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20304-1155 (0704-0411). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 16 U.S.C. 136; 20 U.S.C. 827; DoDI 1315.10; DoDI 1342.12; and E.O. 9367 (SSN) as amended.

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) military assignment personnel to match the special medical needs of family members against the availability of medical services, and (2) civilian personnel officers 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 SORNs may be found at <http://privacy.defense.gov/notices>.

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://privacy.defense.gov/blanket_uses.shtml apply.

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 Social Security 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 noted in the official military personnel files which are retrieved by name and Social Security Number.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing this authorization, you confirm you understand your sponsor will have access to the health information contained herein and in addenda. The sponsor may be held accountable for the accuracy and completeness of the DD 2782 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTR/DTR/Civilian Provider) (Name of Provider)

to release my patient information to the Relocation or Suitability Screening Office and/or the Exceptional Family Member/Special Needs Program to be used in the family travel review process and/or registration in the Exceptional Family Member Program. The information on this form and addenda may be used for DoD and Service-specific programs to determine whether there are adequate medical, housing and community resources to meet your medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs, if EPMP enrollment criteria are met.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment process. Access to the information is limited to representatives from the medical departments, the offices responsible for assignment coordination, and at your request other military agents responsible for care or services.

Start Date: The authorization start date is the date that you sign this form authorizing release of information.

Expiration Date: This authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to criteria specified in DoD Instruction 1315.10, 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 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. 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.

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

e. Failure to release this information or any subsequent revocation may result in ineligibility for community based services, and/or accompanied family travel at government expense.

f. 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) Father	DATE (YYYYMMDD)
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DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM (X one)

<input checked="" type="checkbox"/> EFIP REGISTRATION/ENROLLMENT UPDATE	<input type="checkbox"/> REQUEST CHANGE IN EFIP STATUS	<input type="checkbox"/> FAMILY MEMBER DECEASED*
<input type="checkbox"/> SUBMITTE MEDICAL INFORMATION FOR OFFICIAL USE	<input type="checkbox"/> NO LONGER HAVE PREVIOUSLY IDENTIFIED CONDITION	<input type="checkbox"/> DIVORCE/CHANGE IN CUSTODY*
<input checked="" type="checkbox"/> REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMBAND SPONSORSHIP	<input type="checkbox"/> NO LONGER QUALIFIES AS A DEPENDENT*	
<input type="checkbox"/> OTHER (Explain):	(*Maintain documentation to verify change in status - do not update medical information.)	

2.a. FAMILY MEMBER/PATIENT NAME (Last, First, Middle Initial)	b. SPONSOR NAME (Last, First, Middle Initial)	c. FAMILY MEMBER PREFIX (FMP)	d. SPONSOR SSN
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6. FAMILY MEMBER GENDER (M)	7. FAMILY MEMBER DATE OF BIRTH (YYYYMMDD)	8. CURRENT FAMILY MEMBER MAILING ADDRESS
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All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

4. BRANCH OF SERVICE (Military only)	5. STATUS (X one)
<input checked="" type="checkbox"/> ARMY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS	<input checked="" type="checkbox"/> REGULAR ACTIVE SERVICE MEMBER <input type="checkbox"/> RESERVIST <input type="checkbox"/> CIVILIAN <input type="checkbox"/> ACTIVE GUARD RESERVE PROGRAM (AGR) <input type="checkbox"/> NATIONAL GUARD

1. SPONSOR'S CURRENT UNIT MAILING ADDRESS

396TH Transportation Company
Fort Stewart Ga.

6. SPONSOR'S OFFICIAL E-MAIL ADDRESS	8. DUTY TELEPHONE NUMBER (Include Area Code/Country Code)	9. MOBILE NUMBER (Include Area Code/Country Code)
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10. DOES FAMILY MEMBER RESIDE WITH SPONSOR (X one. If No, explain)

YES NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? (Military only) (X one. If Yes, complete 4.b. - e. below)

<input type="checkbox"/> YES	b. ACTIVE DUTY SPOUSE'S NAME (Last, First, Middle Initial)	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN
<input checked="" type="checkbox"/> NO				

5.a. IS FAMILY MEMBER ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME? (Military only) (X one)

<input type="checkbox"/> YES	b. IF YES, UNDER WHAT SSN	c. NAME OF SPONSOR (Last, First, Middle Initial)	d. BRANCH OF SERVICE
<input checked="" type="checkbox"/> NO			

6. CERTIFICATION. DO NOT CERTIFY BEFORE COMPLETING ENTIRE FORM AND APPENDS.
 By signing below, we certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked below) is complete and accurate.

PARENT/GUARDIAN OR PERSON OF MAJORITY AGE:

a. PRINTED NAME	b. SIGNATURE	c. DATE (YYYYMMDD)
	Sign please	

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR USN
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FOR ADMINISTRATIVE USE ONLY

7. REQUIRED ACTIONS (X one)

<input checked="" type="checkbox"/> FIRST REVIEW OF MEDICAL HISTORY FOR THE FAMILY MEMBER	<input type="checkbox"/> QUALIFIED FOR CHANGE IN EFMP STATUS:	<input type="checkbox"/> FAMILY MEMBER DECEASED
<input checked="" type="checkbox"/> REQUEST FOR GOVERNMENT SPONSORED TRAVEL AND/OR COMMAND SPONSORSHIP - REVIEW PROJECTED LOCATION(S)	<input type="checkbox"/> FAMILY MEMBER NO LONGER HAS PREVIOUSLY IDENTIFIED CONDITION	<input type="checkbox"/> DIVORCE/CHANGE IN CUSTODY
<input type="checkbox"/> UPDATE TO A PREVIOUS EVALUATION FOR THE FAMILY MEMBER	<input type="checkbox"/> FAMILY MEMBER NO LONGER QUALIFIES AS A DEPENDENT*	
<input type="checkbox"/> OTHER (e.g., Extended Care Health Option Eligibility): <i>(*Maintain documentation to verify change in status - do not update medical information.)</i>		

8. SUMMARY (X one)

a.
 b. LO
 c. GA
 (1) NA

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

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:

<input type="checkbox"/> AUTISM ADDENDUM 1 IS REQUIRED AND	<input type="checkbox"/> ATTACHED
<input checked="" type="checkbox"/> MENTAL HEALTH SUMMARY ADDENDUM 2 IS REQUIRED AND	<input type="checkbox"/> ATTACHED
<input type="checkbox"/> AUTISM SPECTRUM DISORDER/DEVELOPMENTAL DELAY ADDENDUM 3 IS REQUIRED AND	<input type="checkbox"/> ATTACHED

11. SPECIAL ASSIGNMENT CONSIDERATIONS (X of that apply)

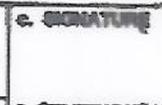
<input type="checkbox"/> a. POSSIBLE SPECIAL EDUCATION/EARLY INTERVENTION (If marked, DD Form 2792-1 must be completed)	<input type="checkbox"/> e. RECEIVING STATE MEDICAID OR MEDICARE WAIVER SERVICES
<input type="checkbox"/> b. RECEIVING TRICARE EXTENDED CARE HEALTH OPTION (ECHO) BENEFITS	<input type="checkbox"/>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

12. ARE THE

YES NO

Get proper signature

13. ADMINISTRATIVE

a. PRINTED NAME (Last, First, Middle Initial)	b. TITLE	c. SIGNATURE	d. DATE (YYYYMMDD)
	Social Service Assist		2011/09/21
e. FACILITY ADDRESS (Include ZIP Code or AFOTFC)	f. TELEPHONE NUMBER (Include area code/Country Code)	g. OFFICIAL STAMP	
COMMANDER WINN ARMY COMMUNITY HOSPITAL EXCEPTIONAL FAMILY MEMBER PROGRAM 1041 HARMON AVENUE SUITE 1000 FORT STEWART GA 31314-6011	(912) 435-6505/6970 D9N: 475-6505/6970 FAX: 435-5050/475-5050		

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	SEASIDE V. ADDRESS PREFIX	SPONSOR SSN
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MEDICAL SUMMARY: To be completed by a Qualified Medical Professional

PART A - PATIENT STATUS (Authorization by patient or parent/guardian included on Page 1 of this form)

1. FOR CHILDREN UNDER AGE 8 ONLY

a. IF PATIENT IS LESS THAN 12 MONTHS OLD, WAS IT A PREMATURE BIRTH? (X one)		b. DATE OF LAST WELL-CHILD EXAMINATION (YYYYMMDD)
<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. WERE ALL DEVELOPMENTAL MILESTONES WITHIN NORMAL LIMITS? (X one. If No, please explain.)		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	

2. TEMPORARY CONDITIONS THAT MAY IMPACT TRAVEL CONSIDERATIONS IN THE NEXT YEAR

a. DIAGNOSIS	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES

d. TIME FRAME (Explain anticipated duration of temporary condition and identify any limitations for activities of daily living and travel limitations.)

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV. Use Item 11 (Comments) if more space is needed.

a. ACTIVE DIAGNOSIS REQUIRING CARE WITHIN LAST YEAR (if Asthma, Cancer or Mental Health within last 5 years)	b. ICD OR DSM REQUIRED	c. MEDICATIONS AND SPECIAL THERAPIES (Also include rate or special consideration medications used within specified time period)	d. COMPLETE FOR THE LAST 12 MONTHS:
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS
			(1) NUMBER OF OUTPATIENT VISITS (2) NUMBER OF ER VISITS (3) NUMBER OF HOSPITALIZATIONS (4) NUMBER OF ICU ADMISSIONS

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
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4. PROGNOSIS FOR EACH ACTIVE DIAGNOSIS IDENTIFIED IN PART A, ITEM 3 (include expected length of treatment, required participation of family members, and if treatment is ongoing)

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

5. TREATMENT PLAN FOR EACH ACTIVE DIAGNOSIS (Medical, mental health, surgical procedures or therapies planned over the next three years)

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

6. CANCER, ADDITIONAL INFORMATION (if not addressed in items 3, 4, and 5) (indicate date of diagnosis, types of treatment, response to treatment, if treatment is active and if treatment completed)

IF TREATMENT COMPLETED, DATE (YYYYMMDD) _____

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
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MEDICAL SUMMARY (Continued): To be completed by a Qualified Medical Professional

PART B - REQUIRED CARE

7. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - SEMIANNUALLY (Twice a year) Q - QUARTERLY M - MONTHLY BI - BI-MONTHLY W - WEEKLY

(1) CARE PROVIDER (X as appropriate)		(2) FREQUENCY (See above)	(1) CARE PROVIDER (X as appropriate)		(2) FREQUENCY (See above)
C01	a. ALLERGOLOGIST/IMMUNOLOGIST		C09	gp. OTORHINOLARYNGOLOGIST	
C02	b. AUDIOLOGIST		C17	hh. ORTHOPEDIC SURGEON - ADULT	
C42	c. CARDIAC/THORACIC SURGEON		C45	il. ORTHOPEDIC SURGEON - PEDIATRIC	
C03	d. CARDIOLOGIST - ADULT		C77	j. PAIN CLINIC	
C05	e. CARDIOLOGIST - PEDIATRIC		C72	kk. PEDIATRIC NURSE PRACTITIONER	
C70	f. CLEFT PALATE TEAM - PEDIATRIC		C30	l. PEDIATRICIAN	
C06	g. DERMATOLOGIST		C48	mm. PEDIATRIC SURGEON	
C08	h. DEVELOPMENTAL PEDIATRICIAN		C32	nn. PHYSIATRIST (Physical Rehabilitation)	
C43	i. DIALYSIS TEAM		C05	oo. PHYSICAL THERAPIST	
C07	j. DIETARY/NUTRITION SPECIALIST		C08	pp. PLASTIC SURGEON - ADULT	

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

C14	q. GENETICS		C19	wn. PULMONOLOGIST - ADULT	
C15	r. GYNECOLOGIST		C76	xx. PULMONOLOGIST - PEDIATRIC	
C17	s. HEMATOLOGIST/ONCOLOGIST - ADULT		C00	yy. RESPIRATORY THERAPIST	
C18	t. HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C20	zz. RHEUMATOLOGIST - ADULT	
C75	u. INFECTIOUS DISEASE		C40	aaa. RHEUMATOLOGIST - PEDIATRIC	
C30	v. INTERNIST		C01	bbb. SOCIAL WORKER	
C21	va. NEPHROLOGIST - ADULT		C42	ccc. SPEECH AND LANGUAGE PATHOLOGIST	
C22	x. NEPHROLOGIST - PEDIATRIC		C41	ddd. TRANSPLANT TEAM	
C23	y. NEUROLOGIST - ADULT		C01	eee. UROLOGIST - ADULT	
C34	z. NEUROLOGIST - PEDIATRIC		C78	ff. UROLOGIST - PEDIATRIC	
C44	aa. NEUROSURGEON		C00	ggg. OTHER (Describe)	
C64	bb. OCCUPATIONAL THERAPIST - ADULT				
C65	cc. OCCUPATIONAL THERAPIST - PEDIATRIC				
C38	dd. OPHTHALMOLOGIST - ADULT				
C27	ee. OPHTHALMOLOGIST - PEDIATRIC				
C67	f. ORAL SURGEON				

FAMILY MEMBER PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SSN
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MEDICAL SUMMARY (Continued): To be completed by a Qualified Medical Professional

8. ARTIFICIAL OPENINGS/PROSTHETICS (X all that apply)

<input checked="" type="checkbox"/> YES	<input type="checkbox"/> IF YES:	<input type="checkbox"/> P01 - GASTROSTOMY	<input type="checkbox"/> P05 - COLOSTOMY
<input checked="" type="checkbox"/> NO		<input type="checkbox"/> P02 - TRACHEOSTOMY	<input type="checkbox"/> P06 - ILEOSTOMY
		<input type="checkbox"/> P03 - CSF SHUNT	<input type="checkbox"/> P07 - OTHER UNSPECIFIED PROSTHETICS (Specify)
		<input type="checkbox"/> P04 - CYSTOSTOMY	<input type="checkbox"/> P08 - OTHER UNSPECIFIED OPENING (Specify)

9. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS

<input type="checkbox"/> R01 - LIMITED STEPS (If Yes, please explain)	<input type="checkbox"/> R03 - AIR CONDITIONING
<input type="checkbox"/> R02 - COMPLETE WHEELCHAIR ACCESSIBILITY	<input type="checkbox"/> R03a - TEMPERATURE CONTROL
<input type="checkbox"/> R04 - SINGLE STORY/LEVEL HOUSE	<input type="checkbox"/> R03b - HEPA FILTER
<input type="checkbox"/> R05 - CARPET PROHIBITED	<input type="checkbox"/> R03c - POLLEN CONTROL
<input type="checkbox"/> R06 - OTHER (Specify)	<input type="checkbox"/> R03d - AIR FILTERING

N/A

EXPLANATION OF SPECIAL CONSIDERATIONS:

10. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT (If marked, describe type of equipment in Item 11 (Comments) below)

<input type="checkbox"/> L05 - APNEA HOME MONITOR	<input type="checkbox"/> L07 - SPLINTS, BRACES, ORTHOTICS
<input type="checkbox"/> L21 - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY	<input type="checkbox"/> L08 - WHEELCHAIR
<input type="checkbox"/> L30 - HOME DIALYSIS MACHINE	<input type="checkbox"/> L12 - HOME OXYGEN THERAPY
<input type="checkbox"/> L13 - HOME NEBULIZER	<input type="checkbox"/> L14 - HOME VENTILATOR
<input type="checkbox"/> L04 - HEARING AID: MAKE: MODEL:	
<input type="checkbox"/> L22 - INSULIN PUMP: MAKE: MODEL:	
<input type="checkbox"/> L23 - PACEMAKER: MAKE: MODEL:	
<input type="checkbox"/> L18 - OTHER (Specify)	

N/A

EXPLANATION OF SPECIAL CONSIDERATIONS:

11. COMMENTS (Enter additional information to describe this individual's medical needs)

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

PART C - PROVIDER INFORMATION

12.a. PROVIDER PRINTED NAME OR STAMP

12.b. SIGNATURE

12.c. DATE (YYYYMMDD)

Get proper signature

FAMILY MEMBER/PATIENT NAME	RELATIONSHIP	DATE OF BIRTH	SPONSOR SSN
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ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY: To be completed by a Qualified Medical Professional

1. PATIENT HAS BEEN EVALUATED OR TREATED FOR ASTHMA WITHIN THE PAST 6 YEARS.
 NO YES IF YES, CONTINUE COMPLETION OF ASTHMA ADDENDUM ITEMS 2-6.

2. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. FREQUENCY	d. APPROXIMATE DATE MEDICATION LAST USED

3. HISTORY ASSOCIATED WITH ASTHMA ATTACKS (X as applicable)

YES	NO	QUESTION
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS (stress, environment, exercise)?
		b. DOES THE FAMILY MEMBER ROUTINELY (greater than 10 days per month/four months per year) USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR (prednisone, prednisolone)? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER 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:
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE (pneumonia, bronchitis, bronchiolitis, COPD, RSV) DURING

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

4. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? (X as applicable)

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3-7 TIMES A YEAR	(5) 8-10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. BUSY ACTIVITY							
c. SOCIALIZING WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

5. SEVERITY LEVEL. What is the family member's severity level based on the current treatment plan? (Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)

a. **INTERMITTENT ASTHMA.** Intermittent symptoms \leq 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms $<$ 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 \geq 80% predicted; variability $<$ 20%.

b. **MILD PERSISTENT ASTHMA.** Symptoms \geq 2 times a week but $<$ 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms $>$ 2 times a month. PEF or FEV1 \geq 80% predicted; variability 20-30%.

c. **MODERATE PERSISTENT.** Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma $>$ 1 time a week. Daily use of inhaled short-acting β_2 agonist. PEF or FEV1 \geq 60% and 80% predicted; variability $>$ 30%.

d. **SEVERE PERSISTENT.** Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 \leq 60% predicted; variability $>$ 30%.

a. PROVIDER PRINTED NAME OR STAMP	b. SIGNATURE	c. DATE (YYYYMMDD)
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d. TELEPHONE NUMBERS (include Area Code/Country Code)	e. MAILING ADDRESS (include ZIP Code)
(1) COMMERCIAL (2) DSN (Military only) (3) FAX NUMBER	
f. OFFICIAL E-MAIL ADDRESS	

ADDENDUM 2 - MENTAL HEALTH SUMMARY: To be Completed by a Qualified Clinical Provider

1. PATIENT HAS CURRENT OR PAST (within the last 6 years) HISTORY OF MENTAL HEALTH DIAGNOSIS (To include attention deficit disorders)
 NO YES IF YES, CONTINUE WITH COMPLETION OF MENTAL HEALTH ADDENDUM.

2. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a.	b.	c.	d.
-----	ICD OR DSM	AGE AT	-----

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

DATE OF LAST ADMISSION:

(1) NUMBER OF OUTPATIENT VISITS

(2) NUMBER OF HOSPITALIZATIONS

(3) NUMBER OF RESIDENTIAL TREATMENT ADMISSIONS

DATE OF LAST ADMISSION:

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

4. HISTORY

YES	NO	WITHIN THE LAST 6 YEARS, HAS THE PATIENT HAD:
	<input checked="" type="checkbox"/>	a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
	<input checked="" type="checkbox"/>	b. HISTORY OF SUBSTANCE ABUSE?
	<input checked="" type="checkbox"/>	c. HISTORY OF ADDICTIVE BEHAVIORS?
	<input checked="" type="checkbox"/>	d. HISTORY OF EATING DISORDERS?
	<input checked="" type="checkbox"/>	e. HISTORY OF OTHER COMPULSIVE BEHAVIORS?
	<input checked="" type="checkbox"/>	f. HISTORY OF PROBLEMS WITH LEGAL AUTHORITY? (If Yes, specify)
	<input checked="" type="checkbox"/>	g. HISTORY OF PSYCHOTIC EPISODES?
	<input checked="" type="checkbox"/>	h. HISTORY OF SERVICES RECEIVED FOR ALLEGATIONS OF FAMILY MALTREATMENT? (If Yes, and services are delivered by Family Advocacy, note case determination.)

I. COMMENTS

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR BIN
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ADDENDUM 2 - MENTAL HEALTH SUMMARY (Continued): To be Completed by a Qualified Clinical Provider

5. PROGNOSIS (include past compliance with treatment programs, expected length of treatment, required participation of family members, and if treatment is ongoing.)

6. TREATMENT PLAN (Medical, mental health, surgical procedures or therapies planned in the patient's mental health condition planned over the next three years)

All areas must be completed if applicable! Information can be hand written or typed, but please ensure it is legible to avoid delay in processing.

<input type="checkbox"/> QUARTERLY ANNUALLY	<input type="checkbox"/> QUARTERLY ANNUALLY	<input checked="" type="checkbox"/> QUARTERLY ANNUALLY	<input type="checkbox"/> QUARTERLY ANNUALLY
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8. OTHER COMMENTS (include additional information that would assist in determining necessary treatments)

10. PROVIDER INFORMATION (Authorization by patient included on Page 7 of this form.)

Get proper signature

FAMILY MEMBER/PATIENT NAME	SPONSOR NAME	FAMILY MEMBER PREFIX	SPONSOR SON								
ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS To be Completed by a Qualified Medical Professional											
1. PATIENT HAS BEEN EVALUATED OR RECEIVED TREATMENT(S) FOR AUTISM SPECTRUM DISORDERS AND/OR SIGNIFICANT DEVELOPMENTAL DELAYS (X one)											
<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES IF YES, CONTINUE WITH COMPLETION OF AUTISM AND SIGNIFICANT DEVELOPMENTAL DELAYS ADDENDUM 3, ITEMS 2 - 14.											
2. DIAGNOSIS(ES) (X and complete as applicable)		3. AGE WHEN DIAGNOSED	4. DATE OF BIRTH (YYYYMMDD)								
<input type="checkbox"/> AUTISTIC DISORDER <input type="checkbox"/> PERVASIVE DEVELOPMENTAL DISORDERS <input type="checkbox"/> ASPERGER'S SYNDROME <input type="checkbox"/> OTHER (Specify)											
5. DIAGNOSED BY:											
<input type="checkbox"/> CHILD PSYCHOLOGIST <input type="checkbox"/> DEVELOPMENTAL PEDIATRICIAN <input type="checkbox"/> CHILD PSYCHIATRIST <input type="checkbox"/> MEDICAL MULTIDISCIPLINARY TEAM		<input type="checkbox"/> OTHER PHYSICIAN <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> SCHOOL-BASED TEAM									
6. COEXISTING DIAGNOSES (X of that apply)											
<input type="checkbox"/> CHROMOSOMAL ABNORMALITIES <input type="checkbox"/> OBSSIVE COMPULSIVE DISORDER <input type="checkbox"/> ATTENTION DEFICIT/HYPERACTIVITY DISORDER		<input type="checkbox"/> INTERMITTENT EXPLOSIVE DISORDER <input type="checkbox"/> CIRCADIAN-RHYTHM SLEEP DISORDER <input type="checkbox"/> GENERALIZED ANXIETY DISORDER, ANXIETY DISORDER, NOS									
<input type="checkbox"/> MAJOR DEPRESSIVE DISORDER, DEPRESSIVE DISORDER, NOS <input type="checkbox"/> SEIZURE DISORDER <input type="checkbox"/> OTHER (Specify)											
7. CURRENT MEDICATIONS (Used to treat diagnoses on this page)											
8. CURRENT INTERVENTION THERAPIES											
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">(1)</td> <td style="width:25%;">(2) SCHOOL</td> <td style="width:25%;">(3) THERAPY</td> <td style="width:25%;">(4) OTHER SOURCE</td> </tr> <tr> <td colspan="4" style="text-align:center;">(5) OTHER</td> </tr> </table>				(1)	(2) SCHOOL	(3) THERAPY	(4) OTHER SOURCE	(5) OTHER			
(1)	(2) SCHOOL	(3) THERAPY	(4) OTHER SOURCE								
(5) OTHER											
All areas must be completed if applicable! Information can be hand written or typed, <u>but please ensure it is legible to avoid delay in processing.</u>											
9. COMMUNICATION DEVICE OR MODALITY		10. BEHAVIOR: CHILD EXHIBITS HIGH RISK OR DANGEROUS BEHAVIOR									
<input type="checkbox"/> COMMUNICATION <input type="checkbox"/> YES <input type="checkbox"/> NO (If Yes, provide details in item 14 below)											
11. COGNITIVE ABILITY (X)		12. EDUCATION (X)									
<input type="checkbox"/> <60 <input type="checkbox"/> UNKNOWN <input type="checkbox"/> 60 - 70 <input type="checkbox"/> INDETERMINATE <input type="checkbox"/> >70		<input type="checkbox"/> RECEIVED EARLY INTERVENTION <input type="checkbox"/> ATTENDS PUBLIC SCHOOL <input type="checkbox"/> RECEIVES SPECIAL EDUCATION <input type="checkbox"/> ATTENDS PRIVATE SCHOOL <input type="checkbox"/> ATTENDS SPECIAL PRIVATE SCHOOL <input type="checkbox"/> IS HOME SCHOOLED									
13. REQUIRED MEDICAL SERVICES (X)		14. RESpite CARE RECEIVED									
<input type="checkbox"/> CHILD PSYCHOLOGY <input type="checkbox"/> CHILD NEUROLOGY <input type="checkbox"/> CHILD PSYCHIATRY <input type="checkbox"/> DEVELOPMENTAL PEDIATRICS <input type="checkbox"/> OTHER (Specify)		<input type="checkbox"/> a. HOURS PER MONTH <input type="checkbox"/> b. SOURCE									
15. GENERAL COMMENTS (Include Functional Levels)											
16. PROVIDER INFORMATION											
a. PRINTED NAME OR STAMP		b. SIGNATURE	c. DATE (YYYYMMDD)								
d. TELEPHONE NUMBERS (Include Area Code)		e. MAILING ADDRESS (Include ZIP Code)									
(1) COMMERCIAL	(2) DDM (Military only)	(3) FAX NUMBER									
f. OFFICIAL E-MAIL ADDRESS											



REPLY TO
ATTENTION OF:

HEADQUARTERS, UNITED STATES FORCES KOREA

UNIT #15237
APO AP 06205-5237

FKCC

29 APR 2009

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: US Forces Korea (USFK) Command Policy Letter #26, Command Sponsorship for Service Members in Area I

1. This policy supersedes USFK Command Policy #26, Command Sponsorship for Camp Red Cloud Enclave, dated 24 September 2008. It remains in effect until specifically rescinded or superseded.
2. References:
 - a. USFK Regulation 614-1, Military Command Sponsorship, 12 Nov 03
 - b. Joint Federal Travel Regulations (JFTR), Appendix Q, OCONUS Tour Lengths/Tours of Duty, Part I: DOD Service Members, 1 Jun 08
 - c. DoD Directive 1315.07, Military Personnel Assignments, 23 Apr 07
 - d. OSD Memorandum, Subject: Korea Tour Lengths, dated 1 Dec 08
3. Area I locations at Uijeongbu and Dongducheon are now authorized two-year accompanied tour lengths. It is my intent to support this tour length policy change by maximizing two-year accompanied tours in Area I.
4. Commanders will ensure that service members who desire to serve an accompanied tour in Area I complete the memorandum at the Enclosure after having been counseled regarding the contents of the Enclosure by an O-5 or above commander. This requirement is to ensure service members are aware of the fact that certain benefits normally associated with command sponsorship are limited in Area I. After being counseled, the service member and the counseling commander will sign the Enclosure, acknowledging the limited availability of services. The command sponsorship packet will include the signed memo and acknowledgement and the Soldier's projected assignment.
5. POC is the J1 Policy and Programs Branch, DSN 723-5632, usfkj1mod@korea.army.mil.

Encl
as


WALTER L. SHARP
General, U.S. Army
Commander

DISTRIBUTION:
A

Sponsorship Personnel Assigned to Area I

2. **Dependents Residing in Area I** – Sponsors who have received a Certificate of Nonavailability from the Area I USAG Red Cloud or Camp Casey Housing office will have the following dependent education support options:

(a) **DoDDS Schools Located at USAG Yongsan** - Sponsors may request enrollment in the DoDDS schools located at USAG Yongsan. Command-sponsored dependents who have been authorized enrollment as an exception to the commuting area shall be enrolled on a Space-Required, Tuition-Free basis. Transportation will not be provided at government expense. Sponsors may elect to transport their dependents to the nearest DoDDS student transportation pickup point.

(b) **Non-DoD Schools Program (NDSP)** - The NDSP provides support and funding for the education of eligible dependents of sponsors assigned at locations where the DoD does not operate a school within commuting distance. Sponsors may elect enrollment at an international school in the surrounding area, may elect a home school program, or may elect a virtual school program. Sponsors electing one of these options for their dependents must obtain approval from the Non-DoD Schools Program (NDSP) office at USAG Yongsan. An application must be completed and approved by the NDSP. For more information, visit <http://www.pac.dodea.mil/ndsp>.

Please read carefully

(c) **Medical** – Camp Red Cloud and Camp Stanley Troop Medical Clinics provide troop care only. The Camp Casey Health Clinic provides care for both Soldiers and Family members. Family members living in the Uijeongbu area (Camp Stanley and Camp Red Cloud) may choose to enroll at either the Camp Casey Health Clinic or Brian Allgood Army Community Hospital (BAACH) at USAG Yongsan for their primary care. Specialty and hospital care will be provided at BAACH or at one of our Host Nation partner hospitals. Family members should maximize use of their TRICARE dental insurance in obtaining dental care from our Preferred Host Nation providers in Area I. Military dental clinics in Area I provide troop care only. Limited routine dental care for family members is available on USAG Yongsan.

(d) **POV Registration & Licensing** - Service members in the grade of E-7 and above and all command sponsored service members may own and register a Privately Owned Vehicle (POV) with USFK. Noncommand sponsored service members in the grade of E-6 and below may be granted an exception to policy to own and register a POV with USFK by the first O-6 in the chain of command and the responsible O-6 US Army Garrison Commander. All service members are eligible to apply for a USFK driver's license (Non-command sponsored service members E6 and below require approval from the first O-5 in their chain of command).

(e) **Child Care Services & PX/Commissary limited availability of children/infant items** – Child Care Services in Area I are limited or not available for small children/infants. The PX/Commissary also has limited items for these family members. Service members can special order items available at the Yongsan PX and Commissary from the Camp Red Cloud or Camp Casey PX/Commissary.

(f) **Finance Entitlements (residing in Area II versus Area I)** – In accordance with JFTR, Chapters 9 and 10, Service members are paid Cost of Living Allowance (COLA), Temporary Lodging Allowance (TLA), and Overseas Housing Allowance (OHA) based on a Service members' Permanent Duty Station (PDS) - not the location of their dependents. The JFTR allows exceptions: when command-sponsored dependents are required by United States Forces Korea to reside in Seoul, members are entitled to Seoul rates if occupying a Key Billet, or if a member has a Secretarial waiver allowing the dependents to reside in Area II. Otherwise if a Servicemember, other than the Key Billet or Secretarial waiver exception, chooses to have their dependents live in an Area other than their sponsor's PDS, which is Area I, they will forgo some financial entitlements (i.e., COLA).

Enclosure 1 – Acknowledgement of Command Sponsorship Benefit Limitations for Command Sponsorship Personnel Assigned to Area I

Memorandum for Record

Subject: Acknowledgement of Command Sponsorship Benefit Limitations in Area I

1. Area I has the following limitations for Service members requesting command sponsorship.

- a. **Housing**

1. Area I does not have government family housing for command sponsored families and must rely on the private sector to support the housing requirement. Service members electing a command sponsored tour in Area I will receive Overseas Housing Allowance (OHA) at the with/dependent rate, be authorized 50% of their JFTR for Household Goods, and have logistical support from the Housing Division for furniture and appliances for the duration of the tour. In addition, Housing referral services will be provided to assist service members and their families in locating suitable private rentals, lease negotiations, translations services and landlord/tenant dispute resolution.

2. USAG Yongsan will support a limited number of command sponsored families from Area I (as determined by the medical support fr must complete an including O6 com: Yongsan housing housing off post. t their JTR, and ha duration of the tour. In addition, Housing referral services will be provide to assist service members and their families in locating suitable private rentals, lease negotiations, translations services and landlord/tenant dispute resolution.

Please read carefully

Area II (i.e., de in Area II re requirement the USAG rate sector rized 50% of es for the

3. Per AR 420-1 Army Facility Management, "Permanent party personnel are entitled to housing allowances to secure private housing in the civilian community if Government housing is not provided." Area I does not have government family housing to support Command Sponsored families. Upon completion of inprocessing at the Housing Services Office at USAG Red Cloud or Camp Casey, a certificate of non-availability for government quarters will be issued to authorize Overseas Housing Allowance (OHA) to secure private rental housing.

4. Area I Command Sponsored Key Billet personnel required by USFK to reside in Seoul are entitled to government family housing or Seoul OHA rates if occupying a Key Billet and residing in private rental housing off post. Command sponsored Service members desiring to reside in government family housing in Seoul will be authorized to place their name on the family housing waiting list at USAG Yongsan as a Priority

3. (AR 420-1 Chap 3-14 Table 3-6 Priority of assignment for family housing). If government family housing is not available and Service member elects to reside in Seoul, OHA for the Service member's permanent duty station is Area I, they will be limited to the OHA "other rate."

- b. **Schools**

1. **Dependents Residing on USAG Yongsan – Department of Defense Dependent Schools (DoDDS)** are available in USAG Yongsan and are provided on a Space Required – Tuition-Free basis for commandsponsored dependents.

Enclosure 1 – Acknowledgement of Command Sponsorship Benefit Limitations for Command

(a) Non-DoD Schools Program (NDSP): The NDSP provides support and funding for the education of eligible family members of service members assigned at locations where the DoD does not operate a school within commuting distance. Service members may elect: enrollment at an international school in the surrounding area; a home school program; or a virtual school program. Service members who elect one of these options for command-sponsored family members must receive prior written approval from the NDSP Manager. More specific information on the Non-DoD Schools Program requirements and limitations can be found at: <http://www.p>

(b) DoD family members shall be enrolled provided at g DoDDS studc

Please read carefully and initial the appropriate line

Best enrollment of each family member will not be members to the nearest

(2) Command sponsored family members who are authorized to live in Area II may attend DoDDS on a space-required, tuition free basis.

(3) Having read my options for DoDD Schools, I indicate my preference by initialing below:

I have no school-aged (5-18 years old) children.

I will enroll my children in a virtual school, I will home school my children, or I will apply for my children to attend an international school. (Enrollment in an International school is not automatic. Applications for International schools must be approved by DoDDS-Korea and is subject to space availability at the International school.)

LA I desire to enroll my school-aged children in USAG-Yongsan but understand the request might not be approved and I will enroll them in a Non-DoD Schools Program.

I desire Command Sponsorship only if my school-aged children can be enrolled in USAG-Yongsan.

c. Medical: In Area I, Camp Red Cloud and Camp Stanley Troop Medical Clinics provide medical care for service members only, while the Camp Casey Health Clinic provides care for both service members and family members. Family members living in the Uijeongbu area (Camp Red Cloud and Camp Stanley) may choose to enroll at either the Camp Casey Health Clinic or Brian Allgood Army Community Hospital (BAACH) at USAG-Yongsan for their primary care. Specialty and hospital care will be provided at BAACH or at a host nation partner hospital. Military dental clinics in Area I provide service member care only. Family members should maximize use of their TRICARE dental insurance in obtaining dental care from preferred host nation providers in Area I. Limited routine dental care for family members is available on USAG Yongsan.

d. POV Registration & Licensing: Service members in the grade of E-7 and above and all command sponsored service members may own and register a Privately Owned Vehicle (POV) with USFK.

Enclosure 1 – Acknowledgement of Command Sponsorship Benefit Limitations for Command Sponsorship Personnel Assigned to Area I

will be limited to the unaccompanied rate and OHA will be limited to "other rate" not the full Area I OHA rate). Current COLA and OHA rates are available at Per Diem Travel and Transportation Allowance Committee website at <http://perdiem.hqda.pentagon.mil/perdiem/>.

2. The undersigned acknowledges counseling the Service member on command sponsorship limitations for Area I. The Service member understands the financial difference of having their families reside in Area II if their Permanent Duty Station is in Area I.

Cdr's Signature _____

29 SEP 2011
Date

LTC, LG
Commanding

Enclosure 1 – Acknowledgement of Command Sponsorship Benefit Limitations for Command Sponsorship Personnel Assigned to Area I

Service Member's Acknowledgement

Subject: Acknowledgement of Command Sponsorship Benefit Limitations in Area I

I have read and understand my entitlement/benefits/privileges as stated in this Acknowledgement and the USFK Reg 614-1 (Military Command Sponsorship Program, Para #6). I understand the financial difference of having my family reside in Area II if my Permanent Duty Station is in Area I. I will contact my unit S1 if my tour status changes or my family departs Korea for longer than 30 days.

I acknowledge receipt of these command sponsorship limitations while assigned to a unit in Area I.

Soldier's Signature _____

28 Sep 2011
Date

SSG, USA