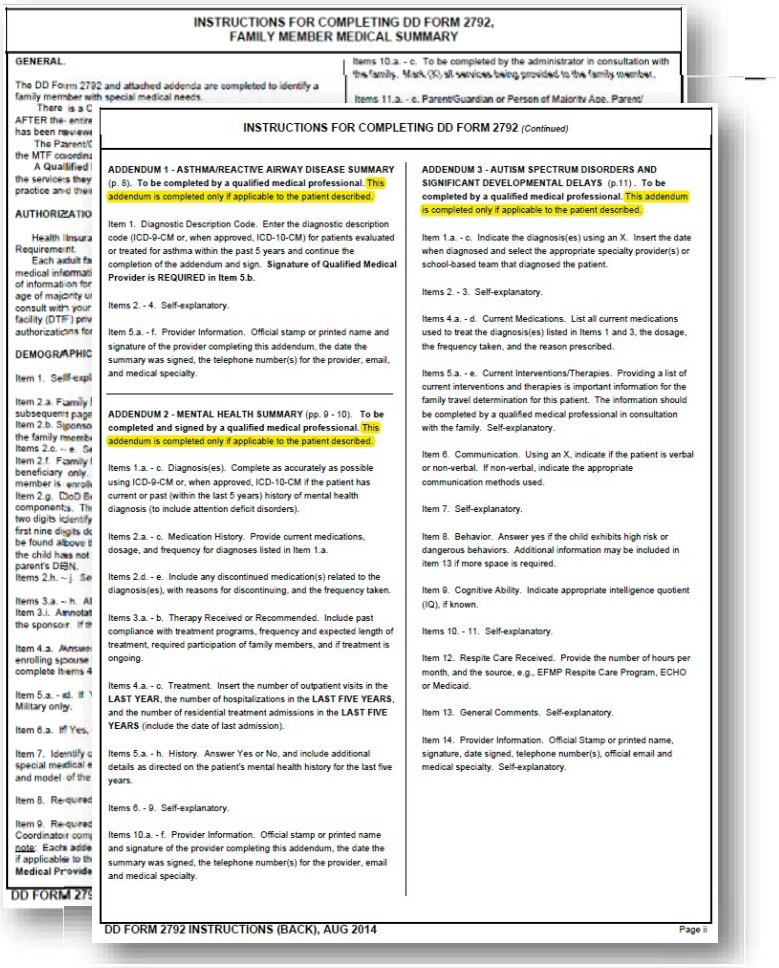
Highlights for the Completion of

DD Form 2792

"Family Member Medical Summary"

- MANDATORY for all EFMP enrollees
- Also used when updating paperwork every **3 years**, when needs change, or dis-enrollment is appropriate.
  - *Note: CAT 6 needs annual updates, & not all dis-enrollment types require DD 2792. See your EFMP team for more information.*
- Turn completed package into EFMP Coordinator

DD Form 2792 Instructions Pages i & ii



INSTRUCTIONS FOR COMPLETING DD FORM 2792, FAMILY MEMBER MEDICAL SUMMARY

GENERAL

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

Items 10.a. - c. To be completed by the administrator in consultation with the family. Mark (X) all services being provided to the family member.

Items 11.a. - c. Parent/Guardian or Person of Majority Age. Parent/

INSTRUCTIONS FOR COMPLETING DD FORM 2792 *(Continued)*

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY (p. 8). **To be completed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Item 1. Diagnostic Description Code. Enter the diagnostic description code (ICD-9-CM or, when approved, ICD-10-CM) for patients evaluated or treated for asthma within the past 5 years and continue the completion of the addendum and sign. **Signature of Qualified Medical Provider is REQUIRED in Item 5.b.**

Items 2. - 4. Self-explanatory.

Item 5.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email, and medical specialty.

ADDENDUM 2 - MENTAL HEALTH SUMMARY (pp. 9 - 10). **To be completed and signed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Items 1.a. - c. Diagnosis(es). Complete as accurately as possible using ICD-9-CM or, when approved, ICD-10-CM if the patient has current or past (within the last 5 years) history of mental health diagnosis (to include attention deficit disorders).

Items 2.a. - c. Medication History. Provide current medications, dosage, and frequency for diagnoses listed in Item 1.a.

Items 2.d. - e. Include any discontinued medication(s) related to the diagnosis(es), with reasons for discontinuing, and the frequency taken.

Items 3.a. - b. Therapy Received or Recommended. Include past compliance with treatment programs, frequency and expected length of treatment, required participation of family members, and if treatment is ongoing.

Items 4.a. - c. Treatment. Insert the number of outpatient visits in the **LAST YEAR**, the number of hospitalizations in the **LAST FIVE YEARS**, and the number of residential treatment admissions in the **LAST FIVE YEARS** (include the date of last admission).

Items 5.a. - h. History. Answer Yes or No, and include additional details as directed on the patient's mental health history for the last five years.

Items 6. - 9. Self-explanatory.

Items 10.a. - f. Provider Information. Official stamp or printed name and signature of the provider completing this addendum, the date the summary was signed, the telephone number(s) for the provider, email and medical specialty.

ADDENDUM 3 - AUTISM SPECTRUM DISORDERS AND SIGNIFICANT DEVELOPMENTAL DELAYS (p.11). **To be completed by a qualified medical professional.** This addendum is completed only if applicable to the patient described.

Item 1.a. - c. Indicate the diagnosis(es) using an X. Insert the date when diagnosed and select the appropriate specialty provider(s) or school-based team that diagnosed the patient.

Items 2. - 3. Self-explanatory.

Items 4.a. - d. Current Medications. List all current medications used to treat the diagnosis(es) listed in Items 1 and 3, the dosage, the frequency taken, and the reason prescribed.

Items 5.a. - e. Current Interventions/Therapies. Providing a list of current interventions and therapies is important information for the family travel determination for this patient. The information should be completed by a qualified medical professional in consultation with the family. Self-explanatory.

Item 6. Communication. Using an X, indicate if the patient is verbal or non-verbal. If non-verbal, indicate the appropriate communication methods used.

Item 7. Self-explanatory.

Item 8. Behavior. Answer yes if the child exhibits high risk or dangerous behaviors. Additional information may be included in item 13 if more space is required.

Item 9. Cognitive Ability. Indicate appropriate intelligence quotient (IQ), if known.

Items 10. - 11. Self-explanatory.

Item 12. Respite Care Received. Provide the number of hours per month, and the source, e.g., EFMP Respite Care Program, ECHO or Medicaid.

Item 13. General Comments. Self-explanatory.

Item 14. Provider Information. Official Stamp or printed name, signature, date signed, telephone number(s), official email and medical specialty. Self-explanatory.

DD FORM 2792 INSTRUCTIONS (BACK), AUG 2014 Page ii

Addendums 1 – 3 are necessary ONLY if applicable to the patient

Addendum 1 (pg. 8)
Asthma/Reactive Airway/Disease Summary

Addendum 2 (pg. 9 – 10)
Mental Health Summary

Addendum 3 (pg. 11)
Autism Spectrum Disorders & Significant Developmental Delays

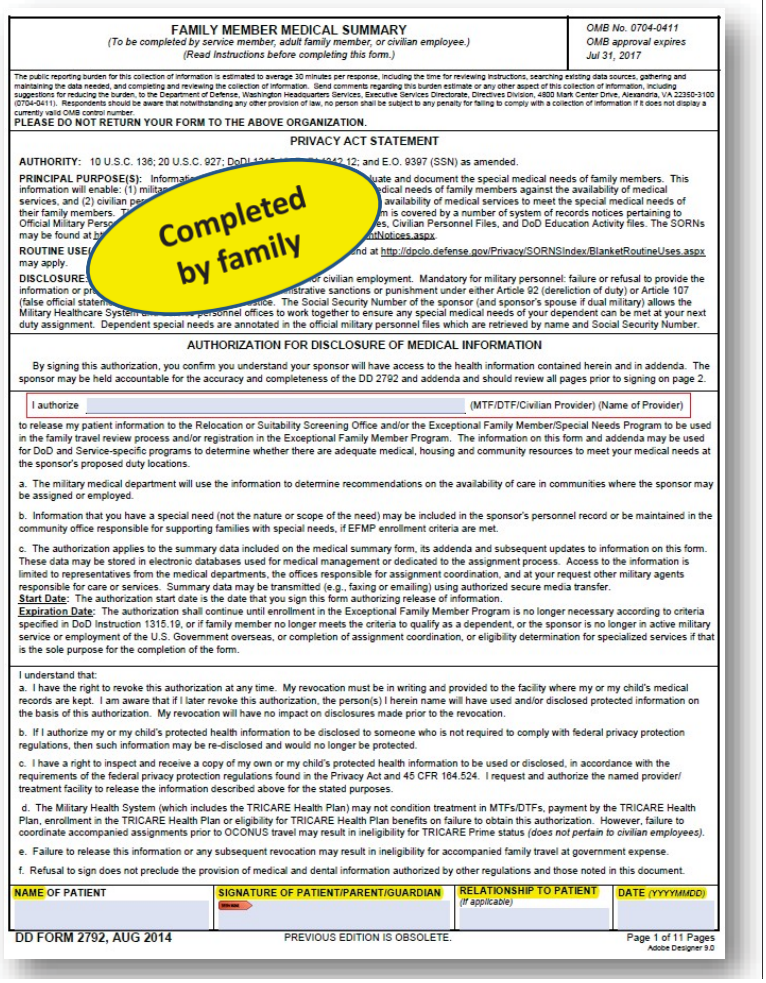
The entire 11-page packet MUST be provided to the medical professional filling out the DD 2792 packet.

Exceptional Families Exceptional Service

DD Form 2792
Page 1

To authorize the release of the patient's medical information, please enter the **name of the Military Treatment Facility or Provider** here.

If the EFM/patient is at Age of Majority, he/she must sign the medical summary. EFMP paperwork can be signed by sponsor's spouse if the patient is a child under the Age of Majority.



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 Jul 31, 2017

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI ... 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Informa... uate and document the special medical needs of family members. This information will enable: (1) milita... dical needs of family members against the availability of medical services, and (2) civilian pe... availability of medical services to meet the special medical needs of their family members. T... m is covered by a number of system of records notices pertaining to Official Military Perso... s, Civilian Personnel Files, and DoD Education Activity files. The SORNs may be found at ... itNotices.aspx

ROUTINE USE(... nd at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx may apply.

DISCLOSURE: ... of civilian employment. Mandatory for military personnel: failure or refusal to provide the information or pr... istrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statem... otice. The Social Security Number of the sponsor (and sponsor's spouse if dual military) allows the Military Healthcare System ... 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 annotated in the official military personnel files which are retrieved by name and Social Security Number.

Completed by family

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 2792 and addenda and should review all pages prior to signing on page 2.

I authorize _____ (MTF/DTF/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 determine 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 EFMP 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. Summary data may be transmitted (e.g., faxing or emailing) using authorized secure media transfer.
Start Date: The authorization start date is the date that you sign this form authorizing release of information.
Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program is no longer necessary according to criteria specified in DoD Instruction 1315.19, 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.

b. If I authorize my or my child's protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own or my child's protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above for the stated purposes.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization. However, failure to coordinate accompanied assignments prior to OCONUS travel may result in ineligibility for TRICARE Prime status *(does not pertain to civilian employees)*.

e. Failure to release this information or any subsequent revocation may result in ineligibility for 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)	DATE (YYYYMMDD)

DD FORM 2792, AUG 2014 PREVIOUS EDITION IS OBSOLETE. Page 1 of 11 Pages

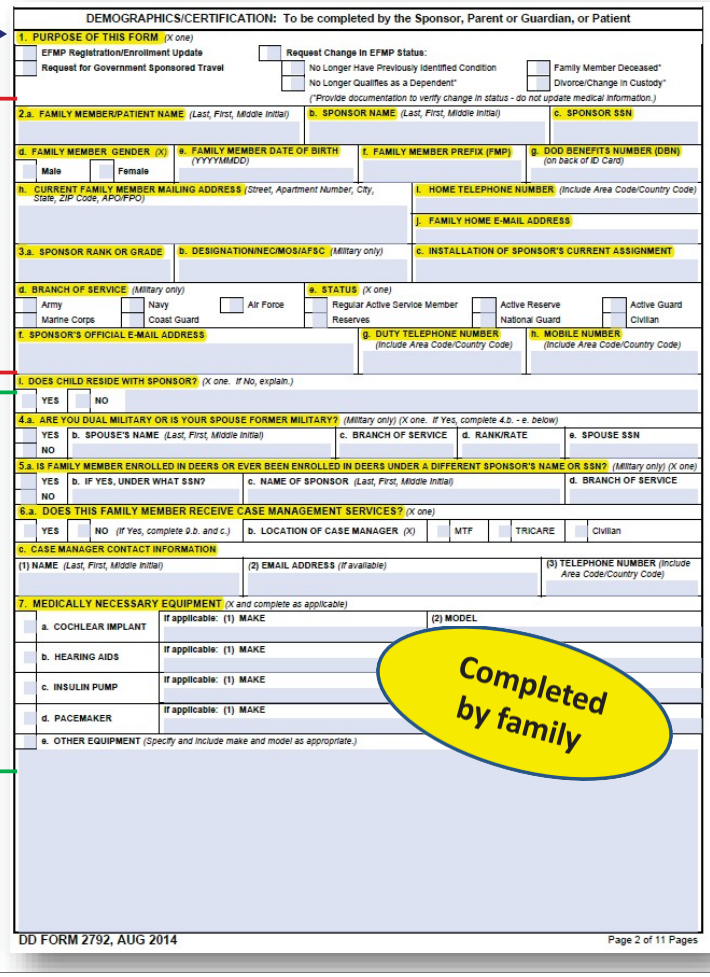
Exceptional Families Exceptional Service

DD Form 2792
Page 2

Check the appropriate box for purpose: Enrollment, change in status, etc.

Family, sponsor, & command information.

Reside with sponsor? Dual military? Enrolled in DEERS? Case management services?



DEMOGRAPHICS/CERTIFICATION: To be completed by the Sponsor, Parent or Guardian, or Patient

1. PURPOSE OF THIS FORM (X one)
EFMP Registration/Enrollment Update
Request for Government Sponsored Travel
Request Change in EFMP Status:
No Longer Have Previously Identified Condition
No Longer Qualifies as a Dependent*
Family Member Deceased*
Divorce/Change in Custody*
(*Provide 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. SPONSOR SSN

d. FAMILY MEMBER GENDER (X)	e. FAMILY MEMBER DATE OF BIRTH (YYYYMMDD)	f. FAMILY MEMBER PREFIX (FMP)	g. DOD BENEFITS NUMBER (DBN) (on back of ID Card)
Male Female			

h. CURRENT FAMILY MEMBER MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO/FPO)	i. HOME TELEPHONE NUMBER (Include Area Code/Country Code)
	j. FAMILY HOME E-MAIL ADDRESS

3.a. SPONSOR RANK OR GRADE	b. DESIGNATION/NEC/MOS/AFSC (Military only)	c. INSTALLATION OF SPONSOR'S CURRENT ASSIGNMENT

d. BRANCH OF SERVICE (Military only): Army, Navy, Air Force, Marine Corps, Coast Guard

e. STATUS (X one): Regular Active Service Member, Reserves, Active Reserve, National Guard, Active Guard, Civilian

f. SPONSOR'S OFFICIAL E-MAIL ADDRESS	g. DUTY TELEPHONE NUMBER (Include Area Code/Country Code)	h. MOBILE NUMBER (Include Area Code/Country Code)

i. DOES CHILD RESIDE WITH SPONSOR? (X one. If No, explain.) YES NO

4.a. ARE YOU DUAL MILITARY OR IS YOUR SPOUSE FORMER MILITARY? (Military only) (X one. If Yes, complete 4.b. - e. below) YES NO

b. SPOUSE'S NAME (Last, First, Middle Initial)	c. BRANCH OF SERVICE	d. RANK/RATE	e. SPOUSE SSN

5.a. IS FAMILY MEMBER ENROLLED IN DEERS OR EVER BEEN ENROLLED IN DEERS UNDER A DIFFERENT SPONSOR'S NAME OR SSN? (Military only) (X one) YES NO

b. IF YES, UNDER WHAT SSN?	c. NAME OF SPONSOR (Last, First, Middle Initial)	d. BRANCH OF SERVICE

6.a. DOES THIS FAMILY MEMBER RECEIVE CASE MANAGEMENT SERVICES? (X one) YES NO (If Yes, complete 6.b. and c.)

b. LOCATION OF CASE MANAGER (X): MTF TRICARE Civilian

c. CASE MANAGER CONTACT INFORMATION

(1) NAME (Last, First, Middle Initial)	(2) EMAIL ADDRESS (If available)	(3) TELEPHONE NUMBER (Include Area Code/Country Code)

7. MEDICALLY NECESSARY EQUIPMENT (X and complete as applicable)

	If applicable: (1) MAKE	(2) MODEL
a. COCHLEAR IMPLANT		
b. HEARING AIDS		
c. INSULIN PUMP		
d. PACEMAKER		
e. OTHER EQUIPMENT (Specify and include make and model as appropriate.)		

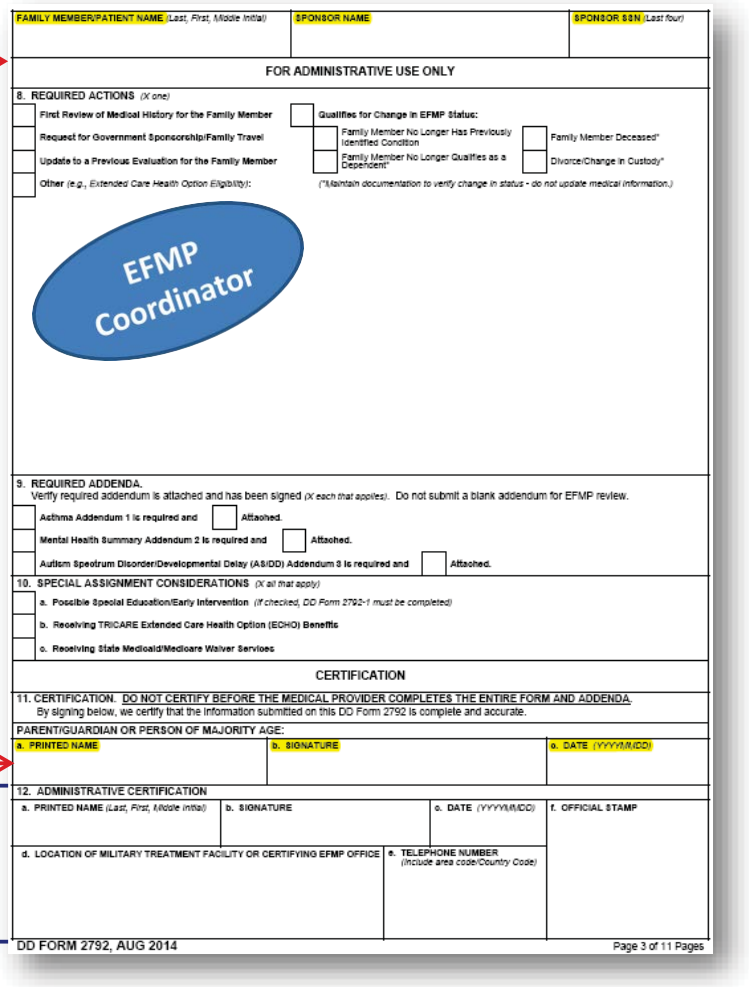
Completed by family

DD FORM 2792, AUG 2014 Page 2 of 11 Pages

Exceptional Families Exceptional Service

DD Form 2792
Page 3

The header section (names & SSN) will auto-populate on each page when completed using the PDF



Signed by the family **AFTER** medical provider completes the form.

EFMP Coordinator reviews package & signs certifying it is complete.

Exceptional Families Exceptional Service

DD Form 2792
Pages 4 & 5

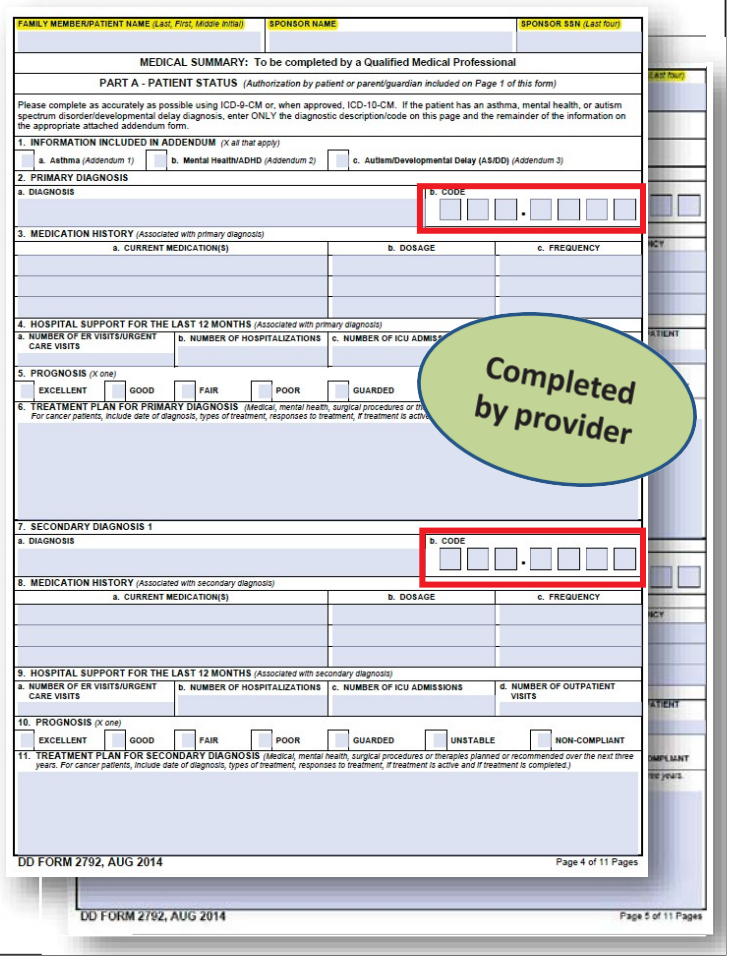
Have a qualified medical provider who knows the family member best fill out the Medical Summary. It may be a PCM, Specialist, or combination.

Pages 4 & 5 have four identical sections for diagnoses information: a primary diagnosis & three secondary diagnosis.

ICD10 codes are mandatory!!

Addendums
(Asthma, Mental health, Autism/Developmental Delay)
are necessary
ONLY IF APPLICABLE
to the patient!

do NOT submit blank addendums!



Exceptional Families Exceptional Service

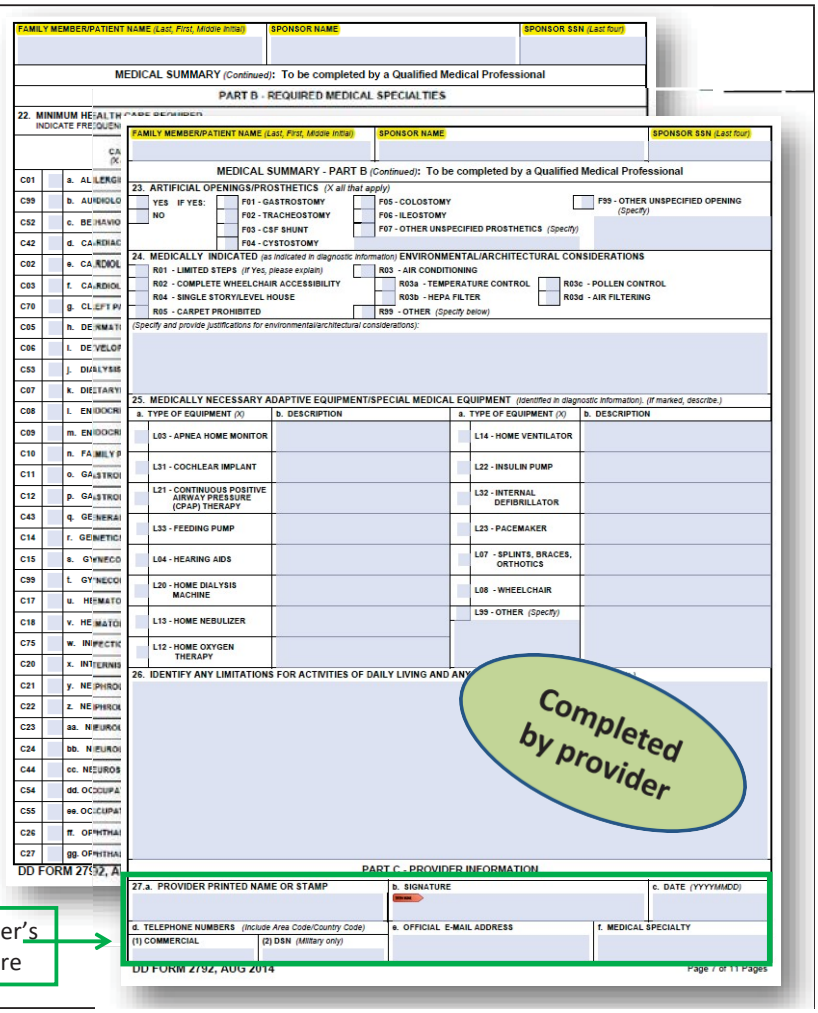
DD Form 2792
Pages 6 & 7

Based on the patient's diagnosis(es), what is the required **minimum** care?

Diagnoses must apply / be relevant to diagnoses! (ex: Dx of Asthma, but seen by neurology & oncology)

Do **NOT** list specialist(s) used to determine a diagnosis but is not necessary for ongoing care.

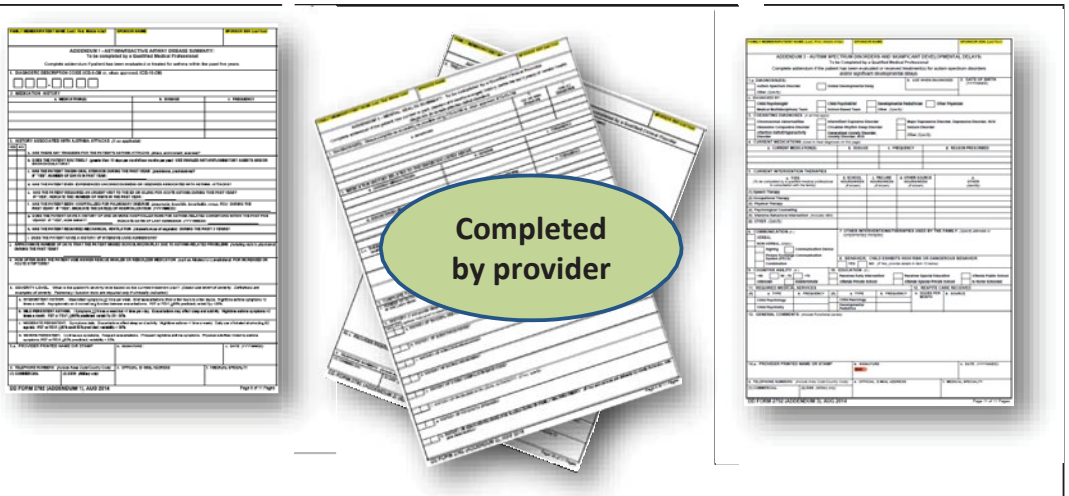
This section is NOT a wish list, but should reflect the providers that are absolutely NECESSARY to meet the needs of the patient.



Medical provider's information here

Exceptional Families Exceptional Service

DD Form 2792
Pages 8, 9-10, 11



Addendums 1 – 3 are necessary

ONLY IF APPLICABLE

to the patient

DO NOT SUBMIT BLANK DOCUMENTS!

Addendum 1 (pg. 8)
Asthma/Reactive Airway/Disease Summary

Addendum 2 (pg. 9 – 10)
Mental Health Summary

Addendum 3 (pg. 11)
Autism Spectrum Disorders & Significant Developmental Delays

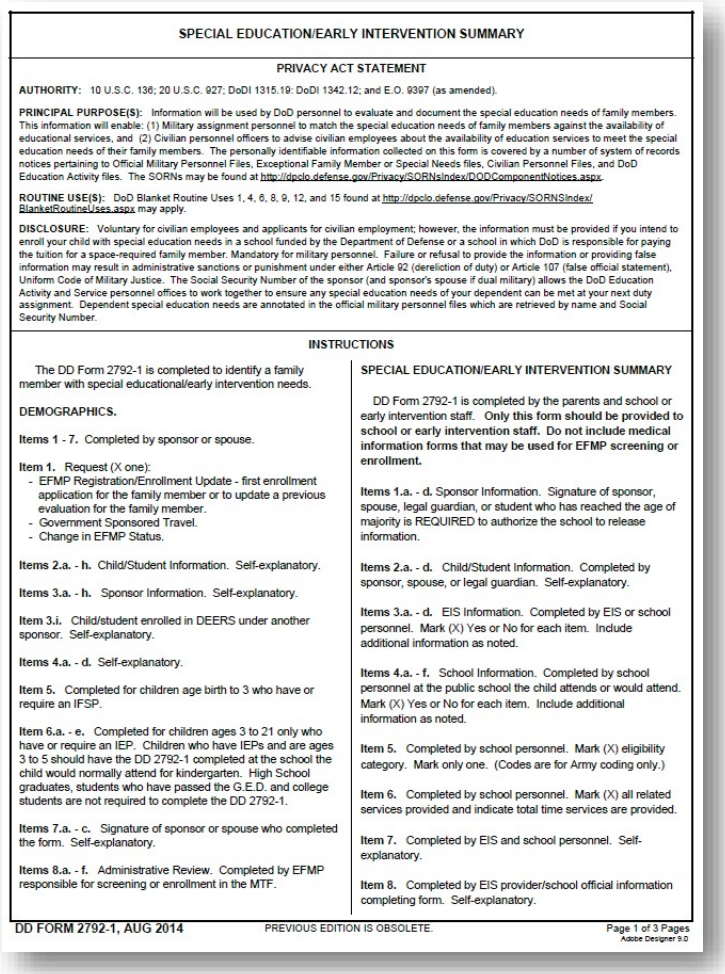
Highlights for the Completion of

DD Form 2792-1

"Special Education / Early Intervention Summary"

DD Form 2792-1 Page 1 Instructions

- DD Form 2792 must be completed for all EFMP enrollees.
- DD Form 2792-1 is required for **ALL** dependents under 18:
  - Required for dependents under 22 if still enrolled in school systems
  - Even if an IFSP/IEP is NOT required, DD Form 2792-1 must still be completed
- Turn completed package into EFMP Coordinator



SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19; DoDI 1342.12; and E.O. 9397 (as amended).

PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special education needs of family members. This information will enable: (1) Military assignment personnel to match the special education needs of family members against the availability of educational services, and (2) Civilian personnel officers to advise civilian employees about the availability of education services to meet the special education 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://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentNotices.aspx.

ROUTINE USE(S): DoD Blanket Routine Uses 1, 4, 6, 8, 9, 12, and 15 found at http://dpclo.defense.gov/Privacy/SORNSIndex/BlanketRoutineUses.aspx may apply.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; however, the information must be provided if you intend to enroll your child with special education needs in a school funded by the Department of Defense or a school in which DoD is responsible for paying the tuition for a space-required family member. 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 DoD Education Activity and Service personnel offices to work together to ensure any special education needs of your dependent can be met at your next duty assignment. Dependent special education needs are annotated in the official military personnel files which are retrieved by name and Social Security Number.

INSTRUCTIONS

The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.

DEMOGRAPHICS.

Items 1 - 7. Completed by sponsor or spouse.

Item 1. Request (X one):
- EFMP Registration/Enrollment Update - first enrollment application for the family member or to update a previous evaluation for the family member.
- Government Sponsored Travel.
- Change in EFMP Status.

Items 2.a. - h. Child/Student Information. Self-explanatory.

Items 3.a. - h. Sponsor Information. Self-explanatory.

Item 3.i. Child/student enrolled in DEERS under another sponsor. Self-explanatory.

Items 4.a. - d. Self-explanatory.

Item 5. Completed for children age birth to 3 who have or require an IFSP.

Item 6.a. - e. Completed for children ages 3 to 21 only who have or require an IEP. Children who have IEPs and are ages 3 to 5 should have the DD 2792-1 completed at the school the child would normally attend for kindergarten. High School graduates, students who have passed the G.E.D. and college students are not required to complete the DD 2792-1.

Items 7.a. - c. Signature of sponsor or spouse who completed the form. Self-explanatory.

Items 8.a. - f. Administrative Review. Completed by EFMP responsible for screening or enrollment in the MTF.

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

DD Form 2792-1 is completed by the parents and school or early intervention staff. **Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.**

Items 1.a. - d. Sponsor Information. Signature of sponsor, spouse, legal guardian, or student who has reached the age of majority is REQUIRED to authorize the school to release information.

Items 2.a. - d. Child/Student Information. Completed by sponsor, spouse, or legal guardian. Self-explanatory.

Items 3.a. - d. EIS Information. Completed by EIS or school personnel. Mark (X) Yes or No for each item. Include additional information as noted.

Items 4.a. - f. School Information. Completed by school personnel at the public school the child attends or would attend. Mark (X) Yes or No for each item. Include additional information as noted.

Item 5. Completed by school personnel. Mark (X) eligibility category. Mark only one. (Codes are for Army coding only.)

Item 6. Completed by school personnel. Mark (X) all related services provided and indicate total time services are provided.

Item 7. Completed by EIS and school personnel. Self-explanatory.

Item 8. Completed by EIS provider/school official information completing form. Self-explanatory.

DD FORM 2792-1, AUG 2014 PREVIOUS EDITION IS OBSOLETE. Page 1 of 3 Pages
Adobe Designer 9.0

Exceptional Families Service

DD Form 2792-1
Page 2

Check the appropriate box for purpose: Enrollment, change in status, etc.

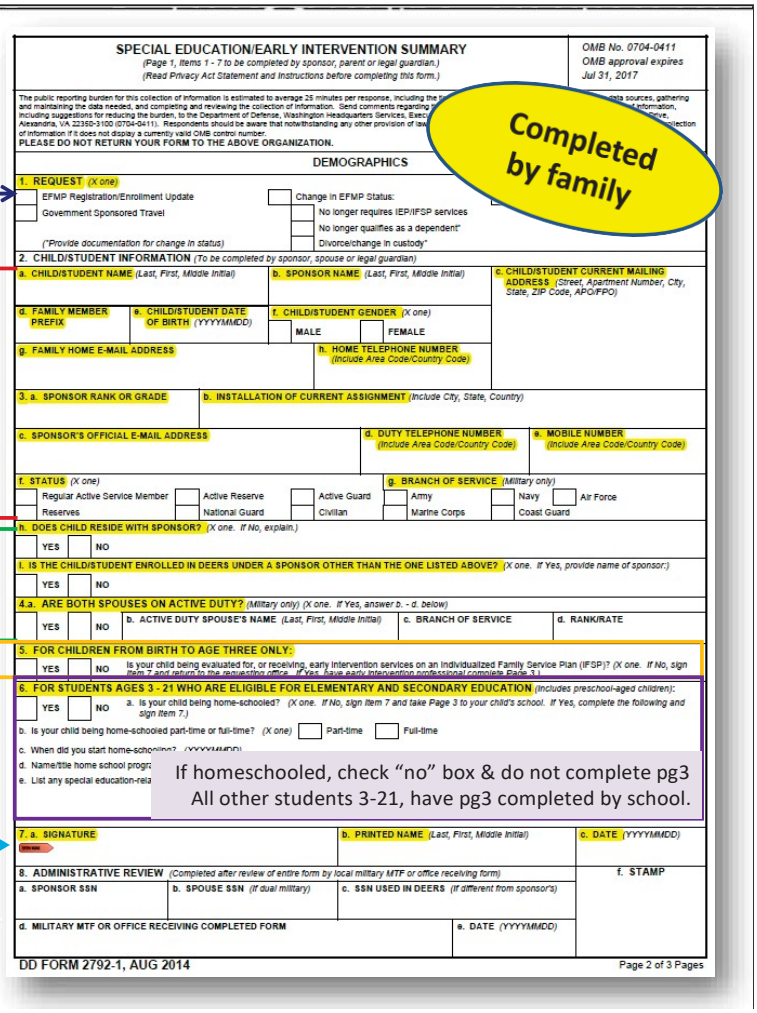
Family, sponsor, & command information.

Reside with sponsor? Enrolled in DEERS? Dual military?

Under 3: if NOT receiving services, do not complete pg3

Can be signed by spouse for child under Age of Majority

EFMP Coordinator reviews package & signs certifying it is complete.



SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

(Page 1, Items 1 - 7 to be completed by sponsor, parent or legal guardian.)
(Read Privacy Act Statement and Instructions before completing this form.)

OMB No. 0704-0411
OMB approval expires Jul 31, 2017

Completed by family

DEMOGRAPHICS

1. REQUEST (X one)
- EFMP Registration/Enrollment Update
- Government Sponsored Travel
- Change in EFMP Status:
  - No longer requires IEP/IFSP services
  - No longer qualifies as a dependent*
  - Divorce/change in custody*

(*Provide documentation for change in status)

2. CHILD/STUDENT INFORMATION (To be completed by sponsor, spouse or legal guardian)

a. CHILD/STUDENT NAME (Last, First, Middle Initial) | b. SPONSOR NAME (Last, First, Middle Initial) | c. CHILD/STUDENT CURRENT MAILING ADDRESS (Street, Apartment Number, City, State, ZIP Code, APO/FPO)

d. FAMILY MEMBER PREFIX | e. CHILD/STUDENT DATE OF BIRTH (YYYYMMDD) | f. CHILD/STUDENT GENDER (X one) MALE FEMALE

g. FAMILY HOME E-MAIL ADDRESS | h. HOME TELEPHONE NUMBER (Include Area Code/Country Code)

3. a. SPONSOR RANK OR GRADE | b. INSTALLATION OF CURRENT ASSIGNMENT (Include City, State, Country)

c. SPONSOR'S OFFICIAL E-MAIL ADDRESS | d. DUTY TELEPHONE NUMBER (Include Area Code/Country Code) | e. MOBILE NUMBER (Include Area Code/Country Code)

f. STATUS (X one): Regular Active Service Member; Reserves; Active Reserve; National Guard; Active Guard; Civilian
g. BRANCH OF SERVICE (Military only): Army; Navy; Air Force; Marine Corps; Coast Guard

h. DOES CHILD RESIDE WITH SPONSOR? (X one. If No, explain.) YES NO

i. IS THE CHILD/STUDENT ENROLLED IN DEERS UNDER A SPONSOR OTHER THAN THE ONE LISTED ABOVE? (X one. If Yes, provide name of sponsor:) YES NO

4.a. ARE BOTH SPOUSES ON ACTIVE DUTY? (Military only) (X one. If Yes, answer b. - d. below) YES NO | b. ACTIVE DUTY SPOUSE'S NAME (Last, First, Middle Initial) | c. BRANCH OF SERVICE | d. RANK/RATE

5. FOR CHILDREN FROM BIRTH TO AGE THREE ONLY: YES NO Is your child being evaluated for, or receiving, early intervention services on an Individualized Family Service Plan (IFSP)? (X one. If No, sign item 7 and return to the requesting office. If Yes, have early intervention professional complete Page 3.)

6. FOR STUDENTS AGES 3 - 21 WHO ARE ELIGIBLE FOR ELEMENTARY AND SECONDARY EDUCATION (Includes preschool-aged children): YES NO
a. Is your child being home-schooled? (X one. If No, sign Item 7 and take Page 3 to your child's school. If Yes, complete the following and sign Item 7.)
b. Is your child being home-schooled part-time or full-time? (X one) Part-time Full-time
c. When did you start home-schooling? (YYYYMMDD)
d. Name/title home school progr
e. List any special education-rela

If homeschooled, check "no" box & do not complete pg3
All other students 3-21, have pg3 completed by school.

7. a. SIGNATURE | b. PRINTED NAME (Last, First, Middle Initial) | c. DATE (YYYYMMDD)

8. ADMINISTRATIVE REVIEW (Completed after review of entire form by local military MTF or office receiving form) | f. STAMP
a. SPONSOR SSN | b. SPOUSE SSN (If dual military) | c. SSN USED IN DEERS (If different from sponsor's)
d. MILITARY MTF OR OFFICE RECEIVING COMPLETED FORM | e. DATE (YYYYMMDD)

DD FORM 2792-1, AUG 2014 Page 2 of 3 Pages

Exceptional Families Service

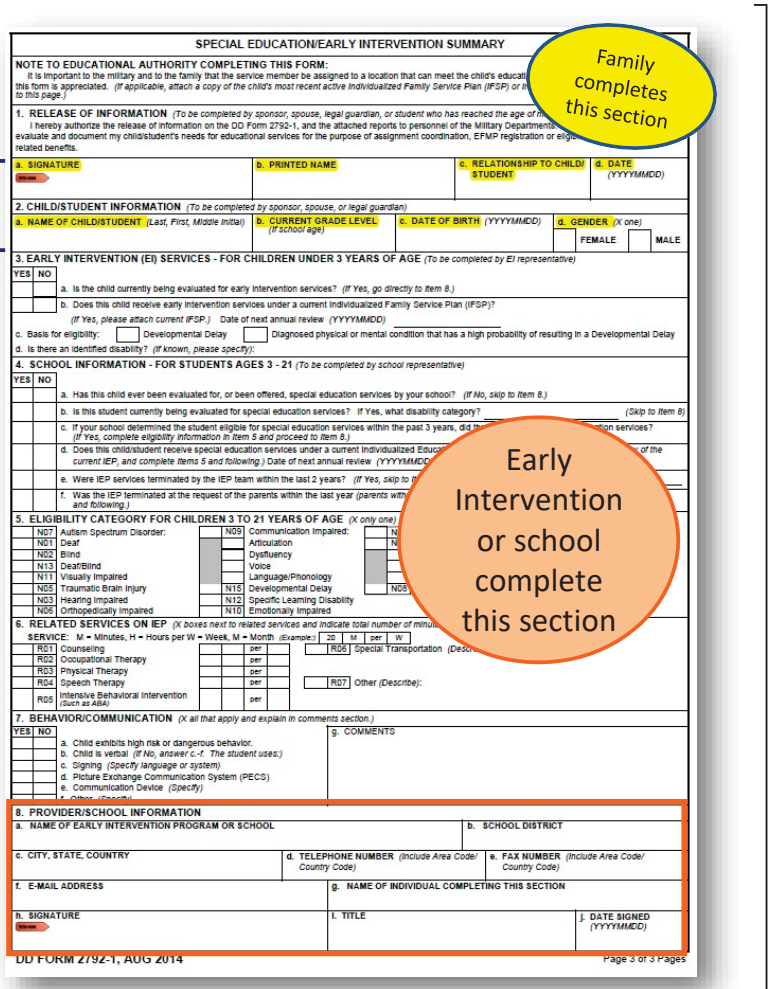
DD Form 2792-1
Page 3

Sponsor/spouse **must** sign & date with student's information to authorize the release of information.

If the child has an IEP or IFSP, it **MUST** be included in the package.

IEP: Individualized Education Plan
IFSP: Individualized Family Service Plan

School/Program representative information here



SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

Family completes this section

NOTE TO EDUCATIONAL AUTHORITY COMPLETING THIS FORM:
It is important to the military and to the family that the service member be assigned to a location that can meet the child's educati
this form is appreciated. (If applicable, attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or I
to this page.)

1. RELEASE OF INFORMATION (To be completed by sponsor, spouse, legal guardian, or student who has reached the age of m
I hereby authorize the release of information on the DD Form 2792-1, and the attached reports to personnel of the Military Department
evaluate and document my child/student's needs for educational services for the purpose of assignment coordination, EFMP registration or eligi
related benefits.

a. SIGNATURE | b. PRINTED NAME | c. RELATIONSHIP TO CHILD/STUDENT | d. DATE (YYYYMMDD)

2. CHILD/STUDENT INFORMATION (To be completed by sponsor, spouse, or legal guardian)

a. NAME OF CHILD/STUDENT (Last, First, Middle Initial) | b. CURRENT GRADE LEVEL (If school age) | c. DATE OF BIRTH (YYYYMMDD) | d. GENDER (X one) FEMALE MALE

3. EARLY INTERVENTION (EI) SERVICES - FOR CHILDREN UNDER 3 YEARS OF AGE (To be completed by EI representative) YES NO
a. Is the child currently being evaluated for early intervention services? (If Yes, go directly to Item 8.)
b. Does this child receive early intervention services under a current Individualized Family Service Plan (IFSP)? (If Yes, please attach current IFSP.) Date of next annual review (YYYYMMDD)
c. Basis for eligibility: Developmental Delay Diagnosed physical or mental condition that has a high probability of resulting in a Developmental Delay
d. Is there an identified disability? (If known, please specify):

4. SCHOOL INFORMATION - FOR STUDENTS AGES 3 - 21 (To be completed by school representative) YES NO
a. Has this child ever been evaluated for, or been offered, special education services by your school? (If No, skip to Item 8.)
b. Is this student currently being evaluated for special education services? If Yes, what disability category? (Skip to Item 8)
c. If your school determined the student eligible for special education services within the past 3 years, did th ion services?
(If Yes, complete eligibility information in Item 5 and proceed to Item 8.)
d. Does this child/student receive special education services under a current Individualized Educa of the current IEP, and complete Items 5 and following.) Date of next annual review (YYYYMMDD)
e. Were IEP services terminated by the IEP team within the last 2 years? (If Yes, skip to
f. Was the IEP terminated at the request of the parents within the last year (parents with and following.)

5. ELIGIBILITY CATEGORY FOR CHILDREN 3 TO 21 YEARS OF AGE (X only one)
N07 Autism Spectrum Disorder; N01 Deaf; N02 Blind; N13 Deaf/Blind; N11 Visually Impaired; N05 Traumatic Brain Injury; N03 Hearing Impaired; N06 Orthopedically Impaired
N09 Communication Impaired: Articulation; Dysfluency; Voice; Language/Phonology
N15 Developmental Delay; N12 Specific Learning Disability; N10 Emotionally Impaired; N08

6. RELATED SERVICES ON IEP (X boxes next to related services and indicate total number of minu
SERVICE: M = Minutes, H = Hours per W = Week, M = Month (Example: 20 M per W)
R01 Counseling; R02 Occupational Therapy; R03 Physical Therapy; R04 Speech Therapy; R05 Intensive Behavioral Intervention (Such as ABA); R06 Special Transportation; R07 Other (Describe):

7. BEHAVIOR/COMMUNICATION (X all that apply and explain in comments section.) YES NO
a. Child exhibits high risk or dangerous behavior.
b. Child is verbal (If No, answer c.-f. The student uses:)
c. Signing (Specify language or system)
d. Picture Exchange Communication System (PECS)
e. Communication Device (Specify)
g. COMMENTS

Early Intervention or school complete this section

8. PROVIDER/SCHOOL INFORMATION
a. NAME OF EARLY INTERVENTION PROGRAM OR SCHOOL | b. SCHOOL DISTRICT
c. CITY, STATE, COUNTRY | d. TELEPHONE NUMBER (Include Area Code/Country Code) | e. FAX NUMBER (Include Area Code/Country Code)
f. E-MAIL ADDRESS | g. NAME OF INDIVIDUAL COMPLETING THIS SECTION
h. SIGNATURE | i. TITLE | j. DATE SIGNED (YYYYMMDD)

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