Welcome to Ramstein EFMP!

This packet allows us to introduce ourselves to your family
and is an informational guide to help you navigate your new EFMP office and care network.

But first, we need to know a few things about you.
Please complete all attached paperwork and return it to our organizational box.
Email EFMP-M: usaf.ramstein.86-mdg.mbx.efmpm@health.mil
Subject line: EFMP in-processing forms (Sponsor's Full Name, Rank)

Forms to be completed:

- ☐ AF Form 2523: Shows you have received and read the EFMP-M informational form
- ☐ DD Form 2005: Privacy Act Statement
- ☐ DD Form 2870: Allows the sponsor to access records for a dependent over the age of 18
- ☐ Ramstein EFMP Initial Contact Form

Our main function is making sure that our families have access to the care they need. One way we do that is through initial and annual contacts. **Please complete the four items above and send them in an email to our organizational box** as soon as you can after your initial arrival to Ramstein. **Also, please mark your calendars for 12 months from now** and email our organizational box on that day to request an annual contact update. The annual update allows us to review your records, update your enrollment status and needs, advocate for you and your family members, and make your PCS process easier when it comes time for you to move on to your next home.

Date of initial arrival to Ramstein: _____ Date to send email for annual update: _____

Email EFMP-M: usaf.ramstein.86-mdg.mbx.efmpm@health.mil
Subject line: EFMP Annual Review (Sponsor's Full Name, Rank)
Initial and Annual review emails should include the following:

☐ Sponsor's Full Name, Rank and SSN ☐ Official Email ☐ Phone Number ☐ Duty phone number ☐ Duty station ☐ Organization ☐ Date arrived on station ☐ DEROS ☐ Home address ☐ List of ALL dependents	For each dependent, please consider including: ☐ Relationship to sponsor ☐ EFMP status ☐ Any diagnoses ☐ Any special services they are using **AND** ☐ Their satisfaction with the level of care ☐ Any mental health services they need or are using ☐ Date of last physical or Pap smear ☐ Any changes to their medications, needs, or services Have you started or stopped seeing a special service provider? Do you need a new provider? Has your dosage or type of medication changed? Do you have any questions or concerns you would like addressed?

What does Ramstein EFMP-M do?

As a team, we oversee Ramstein AFB and 170+ Geographically Separated Units. Our main focus is helping families access the care, support, and benefits they need.

What does this look like…

for outbound families:

- We process medical reassignment requests after a new diagnosis or a change in care needs is identified.
- We work with your new potential base's EFMP office to ensure that your family's needs can be met.
- We provide guidance to Commanders when they are considering command directed movement (such as Humanitarian Reassignment and Early Return of Dependents

for inbound families:

- We match the needs of our new families to the care available at our Military Treatment Facilities and on the local economy.
- When we are unable to match providers and families, we communicate with the losing base's EFMP to explain why travel was denied.
- We process reconsideration requests and review additional medical records. We are constantly collaborating with other bases' EFMP offices to make the family's transition as smooth as possible.

for families that are stationed here:

- We advocate for access to care for any documented medical and educational needs.
- We evaluate new Command Sponsorship applications, including processing Newborn Letters for the youngest family members.
- We maintain an updated list of wait times, providers, specialists, and treatment types in our database of care options. Note: circumstances are always changing; please let us know if/when our lists are out of date and we will do our best to correct it.
- We match care to newly identified needs, or help families navigate the Reassignment process.
- We report Category 1 violations involving:
  - Issues with processing (incorrect orders, documentation, etc.)
  - Families that did not accurately report their needs
  - Families that arrived without completing their clearance.
- We process exception to policy requests from families that are seeking command sponsorship for when travel has not been properly cleared

for everyone:

- We are constantly striving to find ways to make the processes easier to understand and navigate. Please let us know if you have suggestions for improvement.

As you can see, we have a lot of different tasks that need our attention, sometimes involving life or death circumstances. However, we also understand that the long wait times can be very frustrating. One of the ways that you can reduce processing time is to help us understand exactly which task you'd like to complete.

Please use our detailed process checklists or reference the quick guide on page 3

We have detailed informational sheets for each process located outside our office in the Ramstein Clinic, but we also wanted to give you this

Quick Guide for EFMP-M Processes

To make sure your paperwork can be processed most effectively,
Email: **usaf.ramstein.86-mdg.mbx.efmpm@health.mil**
with the following email subject lines and additional information:

Subject: Name of Process **AND** (Sponsor's Full Name, Rank)	***include → in the body of the email:*** ☐ Sponsor's SSN ☐ Sponsor's official email address, ☐ Sponsor's duty station, ☐ Dependent's DoDID#/SSN **AND**
New Command Sponsorship *Examples: marriage, birth, adoption, your active duty spouse retiring/separating, etc.*	☐ Date Sponsor signed in to current base ☐ Date Sponsor became legally responsible for dependent ☐ Any diagnoses, treatments, or special care requirements for the dependent
Newborn Letter Request	☐ Baby's full name ☐ Baby's date of birth ☐ Attach baby's health records* ☐ Name of the person who gave birth ☐ Hospital where baby was born
EFMP Enrollment	☐ New diagnosis or identified educational need
EFMP Disenrollment ***or*** **EFMP Status Review** ***or*** **EFMP Status Update**	☐ Change in care needs or reason for review *Some examples include:* *Your records are not accurate* *You've completed treatment and no longer need care* *Your care provider is no longer able to meet your needs* *Your condition has improved or gotten worse*
DEROS Extension Command Sponsorship Coverage	☐ Date Sponsor first signed in at duty station ☐ Date the individual(s) became a military dependent ☐ Any special needs ☐ Details of duty extension (location, time period)
Dependent Travel Not Approved Appeals	☐ Sponsor's DEROS ☐ Gaining base ☐ Potential reasons why DTNA may have occurred
Reassignment Support	☐ Description of current need ☐ Individuals impacted ☐ Relation to Sponsor ☐ Sponsor's role in care AND steps taken to address issue: ☐ Agencies contacted ☐ Attempts to access resources/care ☐ Any mismatch or change in care

Ramstein EFMP Medical Initial Contact Form

SPONSOR'S NAME (*Last, First, Middle Initial*)		SSN	GRADE	BRANCH OF SERVICE
HOME ADDRESS		HOME PHONE NUMBER		
		DUTY PHONE NUMBER		
ORGANIZATION	DATE ARRIVED ON STATION	OFFICIAL EMAIL		
DUTY SECTION	DEROS	DEPENDENT EMAIL (IF APPLICAPLE)		

LIST ALL DEPENDENTS INCLUDING THOSE NOT ENROLLED IN EFMP (*Please indicate who is enrolled in EFMP and the reason for enrollment next to the dependent's name)*

NAME	RELATIONSHIP TO SPONSOR	REASON FOR ENROLLMENT	PHONE NUMBER

HAVE THERE BEEN ANY NEWLY IDENTIFIED SPECIALITY CARE NEEDS FOR ANY OF YOUR DEPENDENTS SINCE YOUR LAST UPDATE?

ARE ANY OF YOUR PREVIOUSLY IDENTIFIED SPECIALITY CARE NEEDS NO LONGER APPLICABLE?

ARE YOU SATISFIED WITH THE LEVEL OF CARE YOU HAVE BEEN RECEIVING SINCE YOUR IN-PROCESSING/LAST ANNUAL UPDATE?

WOULD YOU LIKE TO BE CONTACTED BY THE SPECIAL NEEDS COORDINATOR TO DISCUSS ANY QUESTIONS/CONCERNS REGARDING YOUR EFMP ENROLLMENT AT THIS TIME?

☐ YES, I WOULD LIKE TO BE CONTACTED

NAME OF PERSON TO BE CONTACTED: _____

PHONE NUMBER: _____

EMAIL: _____

☐ NO, I DO NOT NEED TO BE CONTACTED

EXCEPTIONAL FAMILY MEMBERPROGRAM-MEDICAL (EFMP-M) INFORMATION FORM

Welcometothe Exceptional Family Member Program-Medical (EFMP-M). EFMP-M ensures medical and special education information is considered by the appropriate review authorities priorto authorizing government-sponsored travel for family members. EFMP-M implements the Family Member Relocation Clearance (FMRC) process requirements for EFMP-enrolled sponsors at each Permanent Changeof Station (PCS), and for all sponsors planning to take family members overseas. EFMP-M supports the Exceptional Family Member Program (EFMP) by determining when EFMP enrollment criteria are met, andbyproviding necessary supportinformation when an EFMP Reassignmentis requested.

A vital part ofthe FMRC process is to supportmobile families through relocation, forfamilies ofboth Regular Air Force (RegAF) and DoD civilian sponsors. EFMP-M gathers information about family members' health and special education histories from existing data sources andfrom service providers. EFMP-M determinestheavailability of medical and special education servicesinthe projected location, based onthis review of known family memberconditions, to avoid relocating familymembers to locations that cannot meet their needs. Where special needs are identified, as defined by

Authorizing Special Needs Family Members Travel Overseas at Government Expense, Enclosure 4, the Special Needs Coordinator is required torequest an assignment limitation code, "Q", for RegAF sponsors. This "Q-code" provides a level of protection for families with special needs, to ensure deployments and reassignments are considered in conjunction with the family member's therapeutic program. Families of RegAF members may not travel under

command sponsorship to OCONUS locations that cannot ensure the protection of their federal and DoD benefits and entitlements. Assignment coordination support offered to all DoD-affiliated families, regardless of sponsor's service category or the presence of a documented special need. However, decisions regarding travel remain with the sponsor for DoD civilians and others who are not RegAF.

For RegAF members, EFMP Reassignments and deferments are two ofthe optionsthatmay be considered when services are notavailable at a duty station. However, both retention at the current base and assignmento another base aredependent upon vacancies and manning requirements oftheAir Force. The EFMP-M process is nota "baseof choice" service forthesponsor. RegAF members muststillserveoverseas when ordered, regardless ofthepresence of family members with special needs. Members who are selectedfor overseas assignment to a location where medical or special education services are notavailable for family members may electtheoption ofanunaccompanied short tour. AF Personnel Center(AFPC) retains the final authority on all assignment actions.

It is important youknowthe intended uses ofthe information you provide andthe limitationsonconfidentiality. Military health care records andadministrative records maintained by the Military TreatmentFacility, including our separately maintained Special Needs files and logs, are the property ofthe U.S. Government. The same controls apply to these records as other governmentdocuments. Information disclosed by you to the Special Needs Coordinatororfamily MemberRelocation Clearance Coordinator is considered sensitive information and istreatedas such. This means access to thisinformation is allowed forthepurpose intended,tocoordinatecare through relocation, andas required by law, regulation, judicial proceedings,healthcare facility accreditation orinspection, orwhen authorized bytheidentified patientor parent ofa minor.

IfEFMPenrollmentis initiated, a fileis created tomaintain an ongoing record of services and contacts throughout the length ofthe sponsor's career, orperiod ofEFMPenrollment. Ifno EFMP enrollment is warranted, logs and forms used to coordinate relocation are maintained for2 years after processing for process accountability. Requests for information fromsources outside the Department of Defense will not be honored unless you first givewritten permission for the release of information.

Here are someexamples where limitsonconfidentialitymayapply:

1. Release of information may be required by regulation. We will do everything we can to ensure individuals with the right to know find out only what they need to know. If you are RegAF, your commander or higher chain of command may have the need to know some of the information you disclose to us.

2. If you tell us of a situation involving a violation of military regulations, the Uniformed Code of Military Justice (UCMJ), or civil law, we may be required to divulge that information to the chain of command and/or other authorities.

3. If you voice a threat to harm yourself or someone else, or if family maltreatment is alleged or suspected, we may share information as needed to ensure safety.

4. Where there is a need to know, other DoD health care professionals associated with your family's care may have access to some EFMP-M process information in order to coordinate health care delivery.

5. Exceptional Family Member Program-Family Support (EFMP-FS) may be informed of the presence of Q-code status without accompanying medical information, in order for EFMP-FS to assist families with potential support services that may be available.

6. As part of EFMP case reviews, information may be shared with medical staff and EFMP-FS Coordinators in order to assist with family service plan development.

7. Qualified individuals authorized to conduct officially sanctioned research, administrative and/or legal reviews may review EFMP-M records to evaluate services or to conduct other research toward improving processes or services. Research findings or administrative/process improvement reviews NEVER include individual names or other identifying information.

8. The work of EFMP-M staff is reviewed after each client contact to ensure quality services are provided and standards of care are met.

In accordance with the above guidelines, we will strive to safeguard information obtained from you and ensure only authorized sources with a valid need to know have access.

Please ask the EFMP-M staff any questions you have on EFMP-M or about the use of information obtained in the EFMP-M processes.

EXCEPTIONAL FAMILY MEMBER PROGRAM-MEDICAL (EFMP-M) INFORMATION FORM (Cont'd)

Statement of Understanding

I have read the EFMP-M Information Form and understand that information about family members' health and special education needs will be safeguarded, acknowledging the limitations of confidentiality mentioned above and IAW the Privacy Act of 1974 (DD Form 2005).

Sponsor Signature:

_____ Date: _____

Adult Family Member Signature, if briefed on EFMP-M process:

_____ Date: _____

Adult Family Member Signature, if briefed on EFMP-M process:

_____ Date: _____

I have reviewed the EFMP-M process and purposes to the above-identified client(s) to ensure understanding and have discussed the limits of confidentiality.

EFMP-M Staff member Signature:

_____ Date: _____

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR	7. DATE *(YYYYMMDD)*

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION C OMPLETED

SECTION III - RELEASE AUTHORIZATION

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 medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my 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 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 ss 164.524.

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.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	