Installation EFM Document Checklist

Documents Required in Submitted File:

☐ Garrison Commander's Letter *(Must be dated and signed)*

☐ Respite Care Panel Report *(Must be dated. Include family's civilian email address if possible)*

☐ DA FORM 5189 *(Application – all fields must be completed)*

☐ DA FORM 4700 *(Signed and stamped by PCM)*

☐ Family Needs Assessment

☐ Authorization For Transferring EFMP Respite Care Files *(Accompanies all documents transferred to GenRev)*

Signature Date

DEPARTMENT OF THE ARMY
US ARMY INSTALLATION MANAGEMENT COMMAND
HEADQUARTERS, US ARMY GARRISON, FORT BRAGG
2175 REILLY ROAD
FORT BRAGG, NORTH CAROLINA 28310-5000

December 20, 2022

Directorate of Family and Morale,
Welfare and Recreation

[redacted]
Spring Lake, NC 28390

Dear [redacted] Family,

We are pleased to inform you that your Family is qualified to receive 25 hours of Exceptional Family Member Program (EFMP) respite care each month for [redacted] with a level **four** provider. The Fort Bragg EFMP respite care panel used the Family needs assessment and Department of Army Form 5189 to determine eligibility for services and required level of care. The number of hours authorized in this letter are valid through December 20, 2023, unless otherwise instructed by the Headquarters, US Army Installation Management Command.

We hope that respite care will provide the temporary relief your Family is seeking from regular care-giving responsibilities.

A representative from the Army's Respite Care Network, Strategic Resources, Inc. (SRI) will contact you within 72 hours after receiving your file. You may contact SRI directly at (210) 248-9702. If you have any questions, please contact Ms. Amy Melendez, (910) 907-3395, or email at amy.j.melendez2.civ@army.mil.

Sincerely,

Gary W. Burton
Director, Family and Morale,
Welfare and Recreation

Exceptional Family Member Program (EFMP)
Respite Care Panel Report

Name of Installation:
Fort Bragg

Panel Members:

Name	Agency	E-Mail Address	Telephone Number
Amy Melendez	ACS EFMP	amy.j.melendez2.civ@army.mil	910-907-3395
Barbara Trower-Simpkins	ACS Director	Barbara.j.trowersimpkins.civ@army.mil	910-396-6458
Angielina Villafane	VA Lead	Angielina.m.villafane.civ@army.mil	910-907-5869

Sponsor	**Name of EFM**	**E-Mail Address**	**Telephone Number**
[redacted]	[redacted]	[redacted]	[redacted]

Reviewed respite care packet: Date: 13 Dec 22

- ✓ DA Form 4700
- ✓ DA Form 5189
- ✓ EFMP Enrollment
- ✓ Family Needs Assessment

Recommendation for Respite Care:

Approval: ✓ **Number of hours monthly**: 25 **Level of Care**: 4

Disapproval (please explain):

EFMP Respite Care Panel Chair Person Signature:	**EFMP Respite Care Panel Members Signatures:**

APPLICATION FOR RESPITE CARE FOR CHILDREN AND ADULTS WITH DISABILITIES

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 5, United States Code, Section 301.
PRINCIPAL PURPOSE:	To identify specific disability of individual requiring respite care.
ROUTINE USES:	To identify specific problems that individual with disability is experiencing and to determine type of care needed.
DISCLOSURE:	Providing information is voluntary. Failure to provide information will result in disapproval of prospective respite care user's application.

SECTION A - IDENTIFYING AND RESOURCE INFORMATION

1. NAME *(Person with disability)*	2. NAME *(Parent, guardian, or responsible family member)*

3. BIRTHDATE *(YYYYMMDD)*	4. ADDRESS *(Include ZIP Code)*	5. TELEPHONE NUMBERS
		HOME
		MOTHER *(work)*
		FATHER *(work)*

6. EMERGENCY CONTACT *(Relative, friend, etc.) (Name, address and telephone number)*

IF THIS EMERGENCY CONTACT IS NOT AVAILABLE TO SUBSTITUTE FOR THE CAREGIVER IN AN EMERGENCY, PLEASE GIVE THE NAME, ADDRESS AND TELEPHONE NUMBER OF A PERSON WHO HAS AGREED TO BE AVAILABLE AND TO ACCEPT RESPONSIBILITY FOR THE PERSON WITH A DISABILITY IN THE EVENT YOU CANNOT BE REACHED.

7. LIST OTHER HOUSEHOLD MEMBERS

a. NAME	b. BIRTHDATE *(YYYYMMDD)*

8. PHYSICIAN *(Name, address and telephone no.)*	9. DENTIST *(Name, address and telephone no.)*
10. PREFERRED HOSPITAL *(Name and address)*	11. REGULAR PROGRAM ATTENDED BY INDIVIDUAL *(School, sheltered work, etc.)*

12. DESCRIPTIVE INFORMATION *(Individual with Disability)*

a. DESCRIBE INDIVIDUAL'S DISABILITY

b. DESCRIBE ANY CHRONIC MEDICAL PROBLEMS A CAREGIVER SHOULD BE AWARE OF

c. LIST ANY ALLERGIES		
d. IS THERE A HISTORY OF SEIZURES *(If yes, what kind and how often)*		
e. DESCRIBE ANY SPECIAL EQUIPMENT THE INDIVIDUAL USES *(Braces, wheelchair, etc.)*	f. INDIVIDUAL'S HEIGHT	g. WEIGHT

h. INDICATE THE EXTENT TO WHICH THE INDIVIDUAL CAN DO ANY OF THE FOLLOWING:	
USE TOILET	STAND
TRANSFER INDEPENDENTLY	WALK
TALK	FEED SELF
CLIMB STAIRS	BATHE SELF
DRINK FROM A GLASS	SIT UP ALONE
DRESS SELF	UNDERSTAND WORDS

SECTION B - INSTRUCTIONS FOR CARE AND/OR SUPERVISION

1. LIST ANY MEDICATION GIVEN REGULARLY AND THE PURPOSE FOR WHICH IT IS USED

2. DESCRIBE SPECIAL INSTRUCTIONS FOR HANDLING SPECIFIC MEDICAL CONDITIONS *(Seizures, allergies, etc.)*

3. DESCRIBE SPECIAL INSTRUCTIONS FOR HANDLING BODILY FUNCTIONS *(Toileting, transferring, mobility, feeding, etc.)*

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*
Respite Care Eligibility Review	20090204

The Army, through its Family and Morale, Welfare and Recreation Command (FMWRC), is offering respite care to exceptional family members (EFMs) who meet one or more of the eligibility criteria listed below. A medical provider must indicate whether the EFM meets one or more of the following criteria.

- ☐ 1. Little or no age appropriate self-help skills.
- ☐ 2. Severe continuous seizures activity.
- ☐ 3. Ambulation with neurological impairment that requires assistance with activities of daily living.
- ☐ 4. Tube feeding.
- ☐ 5. Tracheotomy with frequent suctioning.
- ☐ 6. Apnea monitoring during hours of sleep, if another family member must remain awake during monitoring.
- ☐ 7. Inability to control behavior with safety issues requiring constant supervision.
- ☐ 8. Life threatening or chronic condition requiring frequent hospitalizations or treatment encounters, which require extensive family involvement in care giving.

- ☐ The limitation is permanent.
  or
- ☐ The limitation may not be permanent, and the checked criteria are valid for 2 years at your current installation.
- ☐ The Individual does NOT meet any of the above eight eligibility criteria.

Provide a copy of this form to the family for submission to the installation Exceptional Family Member Program Manager.

"Exception revision approved by APD, 23 Feb 2009"

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*	☐ HISTORY/PHYSICAL ☐ FLOW CHART ☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)* ☐ DIAGNOSTIC STUDIES ☐ TREATMENT

Family Needs Assessment

Name of Family member's needing care:_____

Soldier/Parent/Guardian: _____

Age (if under 18): _____ **Date of Birth:** _____

Today's Date: _____ **Review Date (at least annually):** _____

The Family Needs Assessment (FNA) is a tool to obtain information for determining levels of support. It is critical that Family choice, interests and strengths be considered in planning, thereby allowing an alignment of resources with needs. The more information that you provide, the better we can assist your Family member.

1. Tell me about your EFM.

2. What are some of the resources your Family has used for respite care support? Are you accessing any of them now? How have they helped?

3. Is the current deployment/assignment cycle affecting/impacting your Family? When do you have opportunities to relax?

4. What are some of the things your Family enjoys doing? What are some of the activities in which your Family participates? Do you have local and accessible support systems? Please provide some examples.

5. What are some of your concerns regarding the care of your EFM? What skills are needed by those involved in providing respite care for your Family member?

6. What activities does your EFM enjoy doing? What activities is he or she involved in? What are his or her strengths?

7. What type of skills are you looking for in a respite care provider? Are there skills you could teach the potential EFMP respite care provider?

8. How does your EFM communicate his or her likes and dislikes or needs and desires?

9. Are there behavioral concerns the EFM respite care provider needs to know about and for which training is necessary? Please describe in detail.

10. Do you have other Family members enrolled in the EFMP? If yes, please provide detailed information.

11. Do you have a preferred EFM respite care provider(s)? If yes, please list.

12. Agencies you are currently receiving services from:

    TRICARE ECHO_____ Vocational Rehabilitation _____

    Mental Health _____ The ARC _____ Easter Seals _____

    Other (Please List) _____

13. Additional comments/information:

Army Community Service (ACS)
Exceptional Family Member Program (EFMP)

Authorization for Transferring EFMP Respite Care Files

PRIVACY ACT STATEMENT

AUTHORITY : 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used by EFMP personnel to transfer client records to the Government Contractor for all Families using respite care services. The transfer of files is necessary to receive continuation of respite care services.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individuals may not be able to receive EFMP respite care services.

I/We hereby authorize _____
(Name of Installation and Name of EFMP Staff member)

to release respite care files for _____, Date of Birth _____
(Name of EFM)

to the Government Contractor providing Respite Care Services.

Sponsor _____, Rank_____, Unit _____

Duty Phone_____ Spouse's Name _____

Home Phone_____ Cell Phone_____

Address_____

_____

Sponsor/Spouse Signature_____ Date:_____

ACS EFMP Staff Signature_____ Date:_____