EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)

Intake Form

Service Member Information

Name: _____ Rank: _____ DOB: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Unit Information

Division: _____ Brigade: _____ Company: _____

Spouse Information

Name: _____ DOB: _____ Exceptional Family Member ☐ Yes ☐ No

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Family member Needing Assistance Information

Name of EFM Needing Assistance: _____ DOB: _____

Diagnosis: _____

Services Requested: _____

Respite Care Only

EFM's Treating Physician's Name: _____ Treating Physician's Phone #: _____

Treating Physician's Fax #: _____

Additional Family / Household Members

Name: _____	DOB: _____	School: _____	**EFM:** ☐Yes ☐No	**CYSS:** ☐Yes ☐No
Name: _____	DOB: _____	School: _____	**EFM:** ☐Yes ☐ No	**CYSS:** ☐Yes ☐No
Name: _____	DOB: _____	School: _____	**EFM:** ☐Yes ☐ No	**CYSS:** ☐Yes☐No

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Name: _____ DOB: _____ School: _____ **EFM:** ☐Yes ☐ No **CYSS:** ☐Yes☐ No

FOR STAFF USE ONLY:

Mark an ✖ if the EFM receives support (of any kind) after school or within their day program or if the EFM needs additional support that would be helpful to the Family.

- ☐ ACS Agency
- ☐ After School Program
- ☒ Applied Behavior Analysis
- ☐ Child, Youth and School Services
- ☐ Community Based Programs (CSNN, HOP, HOTILC)
- ☐ Day Camp
- ☐ Day Program
- ☐ Department of Human Services
- ☐ Department of Rehabilitative Services
- ☐ ECHO
- ☐ ECI
- ☐ HIPPO
- ☐ Hospital
- ☐ Medicaid/Medicare
- ☐ Mental Health Services
- ☐ Occupational Therapy
- ☐ Overnight Camp
- ☐ Parent, Training and Information Center
- ☐ Physical Therapy
- ☐ Recreation/Cultural Programs
- ☐ Respite
- ☐ RTC
- ☐ Sibling Workgroup
- ☐ Special Olympics
- ☐ Specialized Training of Military Parents (STOMP)
- ☐ Speech
- ☐ SSI/SSI-D
- ☐ Support Group
- ☐ Transportation
- ☐ Tri-Care
- ☐ Unit
- ☐ Other_____

Does any of the following factors prevent the client from accessing additional supports? Please select all options that apply.

- ☐ Transportation
- ☐ Funding
- ☐ Staffing support at program
- ☐ Location
- ☐ Accessibility
- ☐ Availability
- ☐ Age of your Family member
- ☐ Cultural/Language
- ☐ Complex needs of your Family member
- ☐ Time of Day or Week
- ☐ Other_____

Client Follow up Date: _____ Information Entered into CTS: ☐ Yes ☐ No

Staff Signature: _____ Date: _____