

EXCEPTIONAL FAMILY MEMBER PROGRAM HENDERSON HALL Family Transition Checklist

SPONSOR INFORMATION

SPONSOR NAME _____

Sponsor Rank: _____
Sponsor SS# (Last 4): _____

Phone Number: _____
Email Address: _____

CURRENT LOCATION / UNIT INFO

GAINING LOCATION / UNIT INFO

FAMILY INFORMATION

SPOUSE NAME _____

Spouse Email _____

TOTAL # OF BOYS _____

AGES OF BOYS _____

TOTAL # OF GIRLS _____

AGES OF GIRLS _____

EXCEPTIONAL FAMILY MEMBER'S (EFM) NAME: MALE OR FEMALE EFM'S AGE

1 _____
2 _____
3 _____
4 _____

RELOCATION DATES

	SELECT	DAY	MONTH	YEAR
ORDERS EFFECTIVE DATE	_____	_____	_____	_____
ESTIMATED DATE OF TRAVEL	_____	_____	_____	_____
ESTIMATED DATE OF ARRIVAL	_____	_____	_____	_____

NEEDS ASSESSMENT - EFMP

- 1 Do you have a current EFMP enrollment? _____
- 2 Are you familiar with the various programs and services of MCCS? _____
- 3 Are you familiar with the various programs and services of EFMP? _____
- 4 Would you like more information about EFMP or disability awareness? _____
- 5 Would you be interested in a special needs support group? _____
- 6 Would you be interested in EFMP recreational activities? _____

NEEDS ASSESSMENT - HOUSING

- 1 Will your family be applying for on installation military housing? _____
- 2 Have you already applied for housing? _____
- 3 Does your family qualify for priority housing? _____
- 4 What type of accommodations or modifications does your EFM require for housing? _____
- 5 Do you have any animals/service animals? _____

NEEDS ASSESSMENT - TRAVEL

- 1 Does your family have a "Plan My Move" calendar? _____
- 2 Are all medication prescriptions filled w/refills? _____
- 3 What type of modifications are needed for you family's hotel room? _____
- 4 Do you need accommodations for animals? _____

NEEDS ASSESSMENT - MEDICAL

- 1 Do you have copies of your EFM's medical records? _____
- 2 Have you transferred your TRICARE region? _____
- 3 Do you have doctors established at your gaining facility/location? _____
- 4 Will you need doctor appointments within 30 days of your arrival? _____
- 5 Does your EFM have any pharmaceutical considerations? _____

NEEDS ASSESSMENT - SCHOOL

- 1 If applicable, do you have current copies of your EFM's IFSP/IEP or 504? _____
- 2 Does the gaining school district have a copy of the current IFSP/IEP or 504? _____
- 3 Does the school currently provide any assistive technology for your EFM? _____

NEEDS ASSESSMENT - STATE SERVICES

- 1 Does your EFM qualify for SSI (Supplemental Security Income)? _____
- 2 Does your EFM qualify for Medi-caid? _____
- 3 Does your EFM qualify for Developmental Disability Services? _____
- 4 Does your family qualify for WIC/Food Stamps? _____

NEEDS ASSESSMENT - RESPITE/CHILD CARE

- 1 Do your child(ren) need a respite care provider? _____
- 2 Do your child(ren) need a child care provider? _____
- 3 Will your child(ren) be participating in Children, Youth, & Teen Programs (CYTP)? _____

COMMENTS SECTION

If you answered OTHER to any questions, please describe the requirements in this section:

END OF ASSESSMENT