DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

ACTIVE DUTY DEPENDENTS OVERSEAS SCREENING

PRIVACY ACT STATEMENT

Authority: 5 U.S.C. § 301; 10 U.S.C. § 671; 14 U.S.C. § 93(a); 14 U.S.C. § 632; 44 U.S.C. § 3101; The Federal Records Act; PSCINST 1300 (series); Departmental Regulations, and applicable message guidance.

Principle Purpose: Personnel Support of Dependents

Routine Uses: Information will be used by personnel within the Coast Guard to determine suitability to accompany the active duty sponsor on assignment to an overseas permanent duty location. In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act, these records or information contained therein may be disclosed outside the Department of Homeland Security for routine use as follows: In accordance with DHS/USCG-14, Military Pay and Personnel System of Records.

Disclosure: The requested information is VOLUNTARY. However, failure to respond may preclude successful processing of an application for dependent travel/command sponsorship and may lead to administrative or disciplinary action against the sponsor.

Purpose. The purpose of this form is to facilitate determining a dependents' suitability to accompany their active duty sponsor to duty overseas. This includes ascertaining if the dependents (current or those to be acquired en route) understand, are fully prepared for living at the location, and medical or related needs can be met by a Military Treatment Facility or TRICARE authorized provider.

Use. One form will be completed for each dependent of the sponsor. Form shall be completed in conjunction with CG-1300; other CG or DoD forms may be required. A visit to your Primary Care Manager (PCM) is not required, however, complete disclosure to the HSWL Screener is required to make a fully-informed decision. Prior to adding an overseas unit on a sponsor's e-resume, sponsor and dependents shall research the unit/location to determine if it meets their desires and is capable of meeting their medical and other needs. Climate, location, language, finance, and other factors should be considered as well.

This form will contain HIPAA information. Completion of, or update to, this form will be required upon sponsor's receipt of PCS orders to an overseas unit.

PCM Visit. Visit to a PCM is not required but may be needed based on responses. Completion of form DD-2870, Authorization for Disclosure of Medical or Dental Information, will be required in order for CG HSWL to review specific information with your PCM.

Delayed Submission. Delaying submission of this form to the Entry Approval Point may result in denial of entry approval. All portions of the form shall be completed without delay. If dependent is unable to complete the form, or if medical/dental/special need information is not available within a timely manner, HSWL Screener shall complete the form with appropriate comment in the remarks blocks and submit to Command to ensure remittal to the Entry Approval Point within the 15 calendar day requirement. Resubmission of the form with updated medical/dental/special need information shall be completed as soon as possible.

HSWL Screener. HSWL Screener shall be an Independent Duty Health Service Technician or DoD equivalent, USPHS doctor/nurse, CG Physician Assistant, CG contracted medical provider (medical doctor, nurse, or physician assistant), regional practice manager, PCM, or other HSWL designee.

Action. HSWL Screener shall complete the form(s) with the dependent(s) then submit to their servicing Base HSWL or HSWL representative for review and recommendation of departing HSWL office. Communications shall be conducted between Base HSWL representative, dependent, and PCM to clarify any issue of concern. Departing HSWL shall contact Entry Approval HSWL to validate available services. Departing HSWL Senior Medical Executive or designee recommendation shall be annotated on this form and on form CG-1300 Part II. Servicing Base HSWL or HSWL representative shall coordinate the passing of these forms and other case information to the respective Entry Approval Point Base HSWL representative.

Blocks 1-10. Sponsor/dependent shall input information.

Blocks 11-18. HSWL Screener shall ask these questions and fill-in appropriate comments as needed.

Signature Blocks 19-26. HSWL Screener sign/date. Dependent/guardian and Sponsor sign/date. Departing HSWL Senior Medical Executive or designee sign/date with recommendation.

ACTIVE DUTY DEPENDENTS OVERSEAS SCREENING

1. SPONSOR NAME	2. SPONSOR RATE/RANK	3. PRESENT UNIT
4. DEPENDENT NAME	5. AGE	6. RELATION TO SPONSOR

7. PROJECTED LOCATION/UNIT	8. PCM MEDICAL NAME/NUMBER
9. PCM DENTAL NAME/NUMBER	10. SPECIALITY PROVIDER NAME/NUMBER

11. Are you or do you need to be enrolled in CG Special Needs program?	Date of update:	☐ Yes	☐ No
12. Were health records reviewed by HSWL Screener, Military Treatment Facility, or TRICARE Provider?		☐ Yes	☐ No
13. Are all immunizations up to date and do they meet destination requirements?		☐ Yes	☐ No
14. Are there any pending consults or tests that have a bearing on suitability to accompany assignment?		☐ Yes	☐ No
15. Dental conditions:			
a. Dental records reviewed by HSWL Screener, Military Treatment Facility, or Dental Provider?		☐ Yes	☐ No
b. Date of last exam (age 2 and up):			
c. Do you require routine/continuing access to specialized care (e.g., TMJ, periodontal disease)?		☐ Yes	☐ No
d. Are you undergoing active orthodontics treatment?		☐ Yes	☐ No
	If "yes" date started:	Estimate completion:	
16. Do you have any medical conditions requiring ongoing care (more than once per year):			
a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)?		☐ Yes	☐ No
b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)?		☐ Yes	☐ No
c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, UTI, prostate)?		☐ Yes	☐ No
d. Neurological conditions (e.g., seizure, pinched nerve, migraine, neuropathy)?		☐ Yes	☐ No
e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)?		☐ Yes	☐ No
f. Mental health or behavioral conditions (e.g., depression, adjustment/personality disorder, ADD)?		☐ Yes	☐ No
g. Developmental (e.g., motor, cognitive, communication, audio, social/emotional adaptive development)?		☐ Yes	☐ No
h. Alcohol/medication abuse or dependence?		☐ Yes	☐ No
i. Special medical supplies, adaptive equipment, assistive technology devices, special accommodations?		☐ Yes	☐ No
j. Do you take any medications (list all medications)?		☐ Yes	☐ No
k. If exposed to a physically or emotionally demanding environment, could underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a MEDEVAC situation?		☐ Yes	☐ No
17. For dependent females:			
a. Have you had a mammogram?	Date of exam: ☐ N/A	☐ Yes	☐ No
b. Has a breast exam been performed within the past 36 months?	Date of exam:	☐ Yes	☐ No
c. Has a pap smear/pelvic exam been performed within the past 36 months?	Date of exam:	☐ Yes	☐ No
d. Are you currently pregnant?	Due date:	☐ Yes	☐ No
e. If pregnant, have you had previous complications or are there any foreseen complications?	☐ N/A	☐ Yes	☐ No

18. ADDRESS ALL SHADED MARKS

19.HSWL SCREENER OR MEDICAL CARE PROVIDER NAME	20. SIGNATURE	21. DATE

By signing, I confirm all information provided is current, truthful, and accurate as of the date of signature below.

22. DEPENDENT/GUARDIAN SIGNATURE	23. DATE

I understand that attempts to obtain a benefit, to include medical care or government sponsored travel, by withholding information regarding my own/family member(s) care histories, may be reported to my commander and that a knowing and willful false statement on this form is a violation of the UCMJ punishable by fine, imprisonment, and/or early return of dependents. By signing, I confirm all information provided is current, truthful, and accurate as of the date of signature below.

24. SPONSOR/GUARDIAN SIGNATURE	25. DATE

26. RECOMMENDED BY DEPARTING HSWL SENIOR MEDICAL EXECUTIVE OR DESIGNEE (annotate CG-1300 Block II)

NAME:	SIGNATURE	☐ Yes	☐ No