

**COAST GUARD SPECIAL NEEDS ENROLLMENT AND
ASSESSMENT FORM PRIVACY ACT STATEMENT**

Data required by the Privacy Act of 1974 (5 U. S. C. 552a)

AUTHORITY: 14 U. S.C. 8632.

PRINCIPAL PURPOSES: To obtain family information needed to evaluate and document the needs of family members for special education and/or health related services. Information will be used by personnel, Commandant (G-PWL-2), to evaluate and document the health related needs of family members and to document the special education needs of school aged family members. This information will enable assignment personnel to match needs of family members against the availability of special education and health related services by assignment, location, service-wide.

ROUTINE USES: Provide information to Federal Government agencies for coordination of special needs programs, medical care, mental health treatment, and monitoring and tracking of special needs families. Provide information to individuals or organizations providing family support program care under contract to the Federal Government.

DISCLOSURE: The provision of requested information is mandatory from active duty military personnel. Failure to respond may preclude processing requests or consideration for Out-of-CONUS assignments. Proper medical and educational evaluations of family members cannot be made without completion of this form.

Service Member

Date

Spouse

Date

COAST GUARD SPECIAL NEEDS AND ASSESSMENT FORM

Instructions: Complete the following three pages and submit, along with supporting documentation, to your Family Resource Specialist or Family Advocacy Specialist at your Work Life Office

DATE _____

Employee ID # _____

SPONSOR'S NAME _____ SSN# _____

RATE _____ DISTRICT _____ UNIT _____

WORK TEL.# _____ HOME TELE # _____

HOME ADDRESS _____

NAME OF CHILD/SPOUSE WITH SPECIAL NEEDS _____

DATE OF BIRTH OF CHILD/SPOUSE _____

TYPE OF DIAGNOSED SPECIAL NEEDS CONDITION (Hearing, Vision or speech impaired; Cerebral Palsy; Mental Retardation; Attention Deficit Disorder; Downs Syndrome; Spina Bifida; Seizure Disorder; Learning Disabilities; Developmental Delays; Emotionally Disturbed; Hydrocephalus; Chronic illnesses such as heart, kidney, cancer, asthma, blood disorders, tumors; Depression; Head or Spinal Cord Injuries; etc.)

CAUSE OF SPECIAL NEED (if known):

TYPES OF THERAPY/TREATMENT NEEDED OR CURRENTLY RECEIVING (Speech; Physical therapy).

SPECIAL SCHOOLS AND/OR PROGRAMS ATTENDED: (Infant Stimulation; Center Base School; Home Resources; Residential Treatment Facility; Learning Disabled Classes; Resource Room; Special Education Classes; Chemical Substance Program; etc.)

SPECIAL EQUIPMENT NEEDED: (wheelchair; neck, arm leg and/or back braces; crutches, apnea monitor; hearing aids; glasses; modified car or van; feeding devices; communication board (Bliss); etc.):

SUPPORT GROUPS USED, IF ANY: (parents of Down's Syndrome Children; Parent Groups Within Schools; Parents of Learning Disabled Children; National Parent Network on Disabilities; Easter Seals; National Cancer Society; etc.):

SPECIAL PROBLEMS AND/OR CONCERNS: (Availability of Special Schools and/or Programs; Lack of Medical Specialists/Therapists, Medications and Equipment; Support Groups, etc.):

NAME OF FAMILY ADVOCACY SPECIALIST (FAS) AND TELEPHONE NUMBER:

NAME OF FAMILY RESOURCE SPECIALIST (FRS) AND TELEPHONE NUMBER:

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO YOUR FAS OR FRS?

YES _____ DATE _____ NO _____

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO HEADQUARTERS (CG-1112)

YES _____ DATE _____ NO _____

*ESTIMATED DATE/YEAR OF REASSIGNMENT? _____

PLEASE PRINT THIS FORM. Upon completion, please mail to:

**Attention: Family Resource Specialist
U.S. Coast Guard
Health, Safety, and Work-Life Field Office Boston
427 Commercial St.
Boston, MA 02109-1027
Fax # (617) 223-3464**