SUBJECT: Medical Board Submission (EFMP) Procedures

The following is a step-by-step procedure for residents of Island Palm Communities attempting to submit for Tripler Army Medical Center- Medical Board Review.

1. Resident obtains Medical Board Submission Packet from IPC, to include:
    a. Medical Move Over Procedures Handout (this document)
    b. DD-2870
    c. Sample Primary Care Physician Memorandum
    d. Administrative Assistant's Contact Information (the undersigned)
2. DD-2870 Form to be completed by Sponsor/ Service Member
    a. Section I
        i. Part 3: Sponsor/ Service Member SSN
    b. Section II
        i. Part 9: Date when form is signed
        ii. Part 10: State an End Date of which to terminate usage of the information provided or check the "Action Completed" Box
    c. Section III
        i. Part 11: Sponsor/ Service Member's Signature
        ii. Part 12: Sponsor/ Service Member's Relationship to Patient
3. Resident turns in completed packet to the Administrative Assistant (the undersigned)
    a. Packet Includes:
        i. DD-2870
        ii. Primary Care Physician Memorandum
        iii. Supporting Medical Documents
        iv. Optional: Memorandum from Resident
    b. Please do not submit packet to your Community Center. They will not accept it.
4. Any incomplete packets will delay the turnaround time for results.
5. Administrative Assistant submits the completed packet to the TAMC Medical Board for review. (Please allow 7-10 business days for results)
6. Results will be sent to the resident via letter to their home address.
7. If approved, resident will be added to the appropriate priority waitlist.
8. Resident will be contacted when a home that fits the medical requirement is available.
9. Should the TAMC Medical Board approve any requests for AC Priority Maintenance, you will be placed on Emergency Maintenance List.

The point of contact for these procedures is the undersigned.

Respectfully,

Malia Ho'okala, NALP
North Region Administrative Assistant, Island Palm Communities LLC
215 Duck Road, Building 950, Schofield Barracks, HI 96857
Phone: (808) 275-3717 Fax: (808) 275-3729
jhookala@ipchawaii.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	[X] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE TAMC - EFMP **TO RELEASE MY PATIENT INFORMATION TO:**
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
Island Palm Communities, LLC	215 Duck Road Bldg 950 Schofield Barracks, HI 96857
c. TELEPHONE *(Include Area Code)* 808-275-3711	d. FAX *(Include Area Code)* 808-275-3101

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [X] OTHER *(Specify)* Medical Housing Accom. Req.
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	[ ] DATE *(YYYYMMDD)* [ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

Reset

[DATE]

MEMORANDUM FOR Operations Director, Island Palm Communities LLC, 215 Duck Rd., Bldg. 950, Schofield Barracks, HI 96857

SUBJECT: Medical Statements for Housing

The TAMC Housing Review Committee receives a significant number of requests to review each month. To help the committee members make appropriately informed decisions, please have the customer's medical provider submit a detailed medical statement using the following format:

MEDICAL STATEMENT

Reference: Last Name, First Name, Family Member Prefix

Dependent _____, AD, US _____, SSN:

Age:

Specific Medical Diagnoses:

Date of Onset:

Prognosis:

Severity of Condition:

Probable Duration:

Summary of Current Medical Condition:

Medications:

Results of past allergy testing (if applicable):

Frequency of Clinic Visits over Past Year:

Number of ER visits and Hospitalizations over the Past Year:

Signature Block