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Medical Services

FAMILY ADVOCACY PROGRAM



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This base instruction establishes the Charleston Air Force Base (CAFB) Family Advocacy Program (FAP). It explains policies and procedures in accordance with (IAW) Air Force Instruction (AFI) 40-301, *Family Advocacy*, 1 May 2002 for identification, protection, treatment and prevention of family maltreatment and assessment, and identification and treatment of family members with exceptional needs. It assigns responsibilities and explains procedures for the management of the FAP. This instruction requires the identification of Air Force exceptional family members and mandates reporting of all incidents of family maltreatment. This Instruction will be reviewed at least within thirty days of its approval and thereafter, annually by all involved installation personnel as a refresher and for revisions. Changes to the below plans must be coordinated with the Family Advocacy Committee (FAC) Chairperson in advance.

SUMMARY OF REVISIONS

This document has been completely revised and must be reviewed in its entirety.

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1. FAP Mission Statement: The FAP enhances Air Force readiness by promoting family and community health and resilience and advocates for nonviolent communities. The FAP, in concert with installation and community agencies, helps build and sustain healthy communities by developing, implementing, and evaluating programs and policies designed to prevent and treat child and spouse maltreatment. The FAP provides program management, oversight, expert training, and consultation services to its key customers and maintains, analyzes, and reports data on child and spouse family maltreatment. The FAP identifies and supports family members with special medical and/or educational needs.

2. Scope.

2.1. Applies to all military, Department of Defense (DoD), civilian, and family members assigned, attached, in transit, or visiting CAFB.

2.2. References Memoranda of Understanding (MOU) with local civilian agencies collaborating with and supporting the CAFB FAP.

2.3. References Inter-Service Support Agreements (ISSA) with local uniformed services collaborating with and supporting the CAFB FAP.

3. Objectives.

3.1. To provide the mission statement defining the CAFB FAP's purpose, scope of services and the population to be served.

3.2. To provide guidance regarding the membership, functions, and responsibilities of the installation FAC and its subordinate teams.

3.3. To provide procedures to ensure teamwork, coordination and the appropriate exchange of information on FAP activities among all installation agencies.

3.4. To provide installation procedures to ensure that all reports of alleged child or spouse maltreatment are referred to the FAP.

3.5. To provide guidelines to ensure that specific installation policies and procedures are developed to define roles and responsibilities of base agencies involved in the reporting, investigation, and disposition of maltreatment incidents, including child maltreatment incidents occurring in DoD-sanctioned activities.

3.6. To provide mechanisms to ensure specific installation policies and procedures are established by the Child Sexual Maltreatment Response Team (CSMRT) and by the High Risk for Violence Response Team (HRVRT), which outline a coordinated community response.

3.7. To provide specified conditions that may precipitate decisions regarding a child's removal from and/or return to the parents' home and mechanisms for referral to appropriate child welfare resources.

4. References: See [Attachment 1](#).

5. Responsibilities.

5.1. Installation Commander will:

5.1.1. Be responsible for the operations and effectiveness of the installation FAP.

- 5.1.2. Designate the Medical Treatment Facility (MTF) Commander (CC) to administer and monitor the installation FAP.
 - 5.1.3. Establish an installation FAC and appoint the MTF/CC, or Deputy MTF/CC, as chairperson.
 - 5.1.4. Serve as a member of the FAC or delegate this responsibility to a key member of the senior staff.
 - 5.1.5. Promote and ensure cooperation among installation organizations to build healthy, resilient communities in order to prevent and treat family maltreatment.
 - 5.1.6. Ensure ISSAs are executed with other Uniformed Service helping agencies to achieve the FAP mission.
 - 5.1.7. Ensure all DoD personnel comply with mandatory reporting requirements and referral of families for suspected family maltreatment and mandatory referral of sponsors with families with possible special medical and/or educational needs.
 - 5.1.8. Coordinate with local civilian agencies that play a cooperative role in the effective implementation of the FAP. Ensure MOU are executed which document respective responsibilities IAW DoD directives and Air Force (AF) guidance.
 - 5.1.9. Ensure FAP facilities are adequate to support appropriate patient care.
 - 5.1.10. Meet with the Family Advocacy Officer (FAO), at least quarterly, to staff trends with high-risk FAP cases.
 - 5.1.11. In collaboration with the CSMRT ensure full consideration of requests for the Family Advocacy Command Assistance Team (FACAT) assistance on all allegations of multi-victim child sexual maltreatment in DoD-sanctioned activities.
- 5.2. The FAC is a sub-committee of the Community Action Information Board (CAIB). The CAIB will ensure all duties and responsibilities are executed.
- 5.2.1. The MTF/CC or Deputy MTF/CC chairs the FAC.
 - 5.2.2. The FAC will include these members:
 - 5.2.2.1. Installation Commander (or designee).
 - 5.2.2.2. MTF Commander or Deputy MTF Commander.
 - 5.2.2.3. FAO.
 - 5.2.2.4. Family Advocacy Outreach Manager (FAOM).
 - 5.2.2.5. Family Support Center (FSC) Director.
 - 5.2.2.6. Staff Judge Advocate (or designee).
 - 5.2.2.7. Chief or Deputy Chief, Military Personnel Flight (MPF).
 - 5.2.2.8. Installation Chief of Security Forces (or designee).
 - 5.2.2.9. Air Force Office of Special Investigations (AFOSI) Detachment Commander (or designee).
 - 5.2.2.10. Installation Staff Chaplain.

5.2.2.11. Family Member Program Flight Chief.

5.2.2.12. Command Chief Master Sergeant.

5.2.3. The FAC will meet at least quarterly. Additional meetings may be held at the call of the Chairperson.

5.2.4. The FAC will accomplish these tasks:

5.2.4.1. Ensure the implementation of the local FAP according to DoD and Air Force FAP directives.

5.2.4.2. Ensure installation directives are developed to implement the FAP.

5.2.4.3. Review, approve, and support the implementation of the annual FAP Action Plan.

5.2.4.4. Ensure the availability of adequate resources for the effective and efficient implementation of the FAP.

5.2.4.5. Ensure program evaluation activities meet requirements of the Air Force Medical Operations Agency/FAP division (AFMOA/SGZF), and DoD FAP guidance.

5.2.4.6. Establish a cooperative working relationship with all local key agencies involved in addressing prevention and intervention of maltreatment.

5.2.4.7. Ensure all MOUs necessary to implement the FAP are developed, maintained, and periodically reviewed IAW DoD directives and AF guidance.

5.2.4.8. Develop installation policies and procedures to ensure notification of appropriate agencies in incidents of suspected maltreatment.

5.2.4.9. Develop procedures to ensure the safety of victims of family maltreatment, alleged offenders, other family members, and all other members of the community.

5.2.4.10. Establish written policies and procedures for local response to allegations of child sexual maltreatment utilizing the CSMRT and ensure that participating installation personnel are trained annually on their roles.

5.2.4.11. Establish written policies and procedures for notification of the FAP when there is a threat of immediate harm to an individual in the FAP system. Ensure guidelines for utilization of the HRVRT are developed and members are trained annually on their responsibilities.

5.2.4.12. Ensure written policies and procedures are developed for response to both incidents of death due to maltreatment and incidents of child maltreatment in DoD-sanctioned activities.

5.2.4.13. Ensure policy is developed for resolving conflicts between the prosecution and clinical treatment objectives in family maltreatment cases.

5.2.4.14. Ensure written policies and procedures are developed for FAP office and home visit safety, and FAP staff members are trained on these protocols.

5.2.4.15. Maintain minutes of FAC meetings that reflect attendance, content of discussions, and decisions made.

5.2.4.16. Ensure efficient and timely coordination of the Family Member Relocation Coordination (FMRC) process.

5.2.5. FAC chairperson will:

- 5.2.5.1. Ensure that FAC members are trained on their roles and responsibilities at least annually.
- 5.2.5.2. Approve nominations for membership on the FAC, Family Maltreatment Case Management Team (FMCMT), CSMRT, and the HRVRT.
- 5.2.5.3. Appoint a FAC member and alternate to review requests for initiation of the Incident Status Determination Review (ISDR) process.

5.3. The MTF/CC will assume responsibility for these areas of FAP activity:

5.3.1. Staffing and training:

- 5.3.1.1. Serves as chair of the installation FAC.
- 5.3.1.2. Appoint a clinical social worker to serve as the FAO. Also designate and train an alternate to ensure continuity of these programs. Other qualified mental health officers may fill these positions if the installation has no social workers available.
- 5.3.1.3. Appoint a medical officer as the Special Needs Coordinator (SNC).
- 5.3.1.4. Provides administrative support for FAP prevention, maltreatment intervention, the FMRC process, and special needs identification (SNI).
- 5.3.1.5. Ensures all FAP management teams are trained annually on their roles and responsibilities, and on child and spouse maltreatment dynamics.
- 5.3.1.6. Ensures all FAP volunteers receive proper screening, training, and supervision and have received training from the American Red Cross or another organization authorized by the MTF.
- 5.3.1.7. Appoints a technician, or civilian equivalent, as an FMRC Coordinator for the MTF.
- 5.3.1.8. Appoints a primary and secondary medical provider to conduct the medical interview for the FMRC process. Ensures the screening medical providers receive training on their responsibilities.

5.3.2. Service Delivery:

- 5.3.2.1. Ensures the MTF publishes guidelines, which clarify policies, responsibilities, and procedures for all medical personnel who have roles in the FAP mission and services.
- 5.3.2.2. Ensures policies and procedures are established for effective coordination of services between the Life Skills Support Center (LSSC), Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program and Family Advocacy for the continuity of care of FAP clients.
- 5.3.2.3. Ensures all medical personnel notify the FAP of all suspected incidents of family maltreatment.
- 5.3.2.4. Ensures the New Parent Support Program (NPSP) is managed according to AFMOA/SGZF guidelines.
- 5.3.2.5. Ensures all medical personnel notify the SNC of sponsors with family members who may have special medical and/or educational needs.

5.3.2.6. Assumes responsibility for managing and monitoring health care aspects of the FAP.

5.3.2.7. Ensures medical information is accessible to support FAP, SNI and assignment coordination.

5.3.2.8. Ensures that family members with special needs and suspected victims of family maltreatment receive medical and dental assessment, required treatment, and referral to base and community agencies when requested by the FAO, SNC, or physician.

5.3.2.9. Ensures seamless, customer-focused delivery of services for the FMRC and Facility Determination Inquiry (FDI) functions.

5.3.2.10. Ensures all AD family members (FM) are cleared for outside continental United States (OCONUS) travel and all FMs with special needs are cleared for continental United States (CONUS) permanent change of station (PCS) travel.

5.3.2.11. In cases of sudden or unexplained child deaths occurring on the installation, ensures the completion of an appropriate autopsy, notification of the AFOSI and Security Forces Squadron (SFS), and referral of the family to the FAP for immediate assessment and supportive services.

5.3.2.12. Ensures development of a comprehensive FAP prevention program.

5.3.2.13. Ensures FAP prevention programs are integrated with other MTF prevention programs and that services are integrated with other installation Integrated Delivery System (IDS) initiatives.

5.3.2.14. Establishes educational programs to provide annual training to personnel in key agencies including medical, dental, child care and youth center, youth activity volunteers, AFOSI, SFS, FSC, Commanders, First Sergeants (CCFs), and all FAP committees and management team members.

5.3.3. Program Administration:

5.3.3.1. Appoints the FAOM as the FAP representative to the IDS.

5.3.3.2. Ensures office space, equipment and furnishings, operating supplies, utilities, maintenance, and other required resources are provided.

5.3.3.3. Ensures computer hardware, software, and Internet access to support AFMOA/SGZF, to meet Congressional and DoD-mandated data requirements, are provided.

5.3.3.4. Maintains equipment/systems that are purchased by AFMOA/SGZF for installation FAP use.

5.3.3.5. Provides environmental and security measures in accordance with Air Force Inspection Agency (AFIA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and state and federal guidelines for sensitive information services. Ensures each FAP facility has a personnel security duress system.

5.3.3.6. Establishes a Family Advocacy process improvement program, which is included in the MTF quality management program.

5.3.3.7. Protects the privacy of sensitive information contained in Family Advocacy, SNI, NPSP and Family Advocacy Strength-based Therapy (FAST) services records.

5.3.3.8. Ensures procedures for the quarterly Wing Commander (AW/CC) FAP brief are developed with the FAO.

5.3.3.9. Oversees the administration of the FMRC/FDI process IAW AFMOA/SGZF guidelines.

5.3.3.10. Establishes a procedure to notify the MTF Commander of all family maltreatment-associated deaths that occur on or off the installation.

5.3.3.11. Refers clients to the health benefits office to obtain information on TRICARE and the Programs for Persons with Disabilities (PFPWD).

5.4. The FAO will:

5.4.1. Manage the installation FAP according to AFMOA/SGZF guidance.

5.4.2. Ensure notification to sponsor's CC, AFOSI unit and the Security Force Squadron/Office of Investigations (SFS/SFOSI), as needed, of all suspected incidents of family maltreatment.

5.4.3. Chair the FMCMT, CSMRT, HRVRT, and the NPSP team case-staffing meeting.

5.4.4. Ensure integration of all FAP prevention components.

5.4.5. Ensure timely evaluation of all maltreatment referrals to FAP.

5.4.6. Ensure the local public child protective agency is notified of all child abuse incidents.

5.4.7. Ensure FAP services and referral resources are included in the installation IDS information and referral guide.

5.4.8. Supervise FAP staff.

5.4.9. Notify AFMOA/SGZF when a civilian position becomes vacant.

5.4.10. Maintain FAP records according to AFMOA/SGZF standards and other AF and DoD guidance.

5.4.11. Ensure completion of the annual FAP Action Plan.

5.4.12. Complete FAP reports and submit case data according to AFMOA/SGZF guidance.

5.4.13. Establish procedures for the security of FAP records and resources.

5.4.14. Serve as a member of the FAC.

5.4.15. Serve as consultant on family maltreatment to installation units and agencies.

5.4.16. Serve as consultant on all suspected child maltreatment in DoD-sanctioned activities.

5.4.17. Maintain working knowledge of the AF FAP website.

5.5. The Special Needs Coordinator will:

5.5.1. Establish procedures for the identification of sponsors with family members with special needs.

5.5.2. Oversee the FMRC process, collaborating with the FMRC coordinator on timely completion of FMRCs and FDIs.

- 5.5.3. Coordinate with the MPF on the Special Needs Screener (SNS), initiation and deletion of Q-codes, the FMRC process, and special needs reassignment/deferment requests.
- 5.5.4. Ensure all FAP personnel are familiar with Child Find.
- 5.5.5. Ensure special needs services and referral resources are incorporated in the installation IDS information and referral system.
- 5.5.6. Maintain working knowledge of community and national resources specific to the special needs population.
- 5.5.7. Maintain working knowledge of the DoD and AF special needs websites.
- 5.5.8. Educate medical personnel and base agencies on mandatory identification of sponsors with family members with special needs and referral requirements and procedures.
- 5.5.9. Comply with the collection and reporting of data as required by AFMOA/SGZF.
- 5.6. Unit Commanders, First Sergeants, and Supervisors (military or civilian) will:
 - 5.6.1. Have a working knowledge of the FAP, including, procedures and policies.
 - 5.6.2. Refer active duty members to the SNC if there are concerns that special medical and/or educational need exists for family members.
 - 5.6.3. Report all suspicions of family maltreatment to the FAP.
 - 5.6.4. Direct suspected AD family maltreatment offenders to the FAP.
 - 5.6.5. Provide information and referral to AD members and eligible beneficiaries on the FAP prevention and maltreatment intervention services.
- 5.7. The Installation Staff Chaplain will:
 - 5.7.1. Serve as a member of the FAC.
 - 5.7.2. Encourage chapel organizations to support FAP and special needs activities and programs.
 - 5.7.3. Provide support ministries as needed.
 - 5.7.4. Nominate a chaplain to serve on the FMCMT.
 - 5.7.5. Ensure all staff working directly with children/youth receive training on identification and reporting procedures for suspected family maltreatment when hired, and annually thereafter.
- 5.8. The Staff Judge Advocate (SJA) will:
 - 5.8.1. Serve, or designates an attorney to serve, on the installation FAC.
 - 5.8.2. Nominate an attorney to serve on the FMCMT, CSMRT, and HRVRT.
 - 5.8.3. Provide consultation to the FAC in the development of MOUs and ISSAs.
 - 5.8.4. Provide consultation services to the FAP.
 - 5.8.5. Provide information about legal rights of family members with special medical and/or educational needs.
 - 5.8.6. Coordinate with the FAO to ensure ready availability and effectiveness of Victim Witness Assistance Program, (VWAP) services for qualifying families.

5.9. The Installation Chief of Security Forces will:

5.9.1. Serve, or designate a senior member to serve, on the FAC.

5.9.2. Serve, or nominate a senior member of SFS, as a representative to the FMCMT and HRVRT.

5.9.3. Ensure SFS staff responsible for responding to domestic incidents are available to attend annual training provided by FAP staff on the identification and reporting procedures for suspected family maltreatment.

5.9.4. Report all allegations/suspicious of family maltreatment to the FAP.

5.9.5. Coordinate investigations of child and spouse maltreatment with AFOSI.

5.9.6. Provide the FAP timely information (including blotter entries, DD Form 1569, **Incident/Complaint Report**, 1 July 1972) concerning all incidents or complaints of family maltreatment.

5.9.7. Support investigative interviews of alleged criminal offenders in cases occurring in DoD-sanctioned activities, but not rules violations. Additionally, the alleged criminal offense must also come under the jurisdiction of the security forces.

5.10. The Installation AFOSI Detachment Commander will:

5.10.1. Serve, or designates a senior representative to serve, on the installation FAC, FMCMT, CSMRT, and HRVRT.

5.10.2. Ensure all staff receive training on the identification and reporting procedures for suspected family maltreatment when hired, and annually thereafter.

5.10.3. Report all allegations/suspicious of family maltreatment to the FAP.

5.10.4. Search the Defense Clearance and Investigations Index (DCII) and its internal database for historical data pertaining to all reported incidents of child maltreatment, and on serious spouse mal-treatment, and provide this information to the FAP.

5.10.5. Investigate aggravated assaults, sexual assaults, and all incidents of child sexual abuse.

5.10.6. Coordinate and monitor child and spouse maltreatment investigations conducted by civilian agencies.

5.10.7. Ensure all agents receive annual training on child and spouse maltreatment issues and procedures.

5.11. The MPF Commander will:

5.11.1. Serve, or designate the Deputy Chief to serve, on the installation FAC.

5.11.2. Coordinate all applications for special needs reassignments or deferments with the unit commander and the MTF.

5.11.3. Ensure newly assigned MPF staff in Outbound Assignments receive training on responsibilities for identification and assignment coordination for sponsors with family members with special needs.

5.11.4. Ensure all incoming AD members with family members are screened for special needs.

5.11.5. Update Assignment Limitation "Code Q" at the request of the Special Needs Coordinator.

- 5.11.6. Ensure FMRC has been accomplished before issuing PCS orders.
- 5.11.7. Notify the SNC of special needs reassignment request results.
- 5.12. The Services Squadron Commander will:
 - 5.12.1. Appoint the Family Member Program Flight Chief to serve on the FAC.
 - 5.12.2. Nominate the Family Member Support Flight Chief or the Child Development Center (CDC) Director or the Youth Director, to serve on the FMCMT.
 - 5.12.3. Ensure staff who work directly with children/youth receive training on identification and reporting procedures for suspected family maltreatment when hired, and annually thereafter.
 - 5.12.4. Ensure staff working with children, age's birth to three years, are aware of the qualifications and referral procedures for Child Find and the NPSF.
 - 5.12.5. Immediately report suspected incidents of child maltreatment occurring in an "out-of-home" care setting, such as child development centers, recreation programs, or family child care homes to the FAP.
 - 5.12.6. Develop effective policy, in coordination with the FAC, for screening applicants seeking positions working with children and youth.
 - 5.12.7. Provide and manage nondiscriminatory recreation activities and club programs, including special needs group projects, for children with special medical and/or educational needs.
 - 5.12.8. Consult with SJA to determine proper jurisdiction and course of action for investigating/resolving situations where a child care provider/youth program staff is suspected of child abuse and/or neglect at a base center or other DoD-sanctioned activity.
- 5.13. The FSC Director will:
 - 5.13.1. Serve as a member of the FAC.
 - 5.13.2. Nominate FSC staff member to serve on FMCMT.
 - 5.13.3. Ensure coordination of referrals and services for FAP and special needs families.
 - 5.13.4. Ensure annual training of FSC staff on family maltreatment dynamics and referral procedures to the FAP.
- 5.14. The Public Affairs Office will:
 - 5.14.1. Distribute FAP news releases to installation newspapers and other news media, after approval by the chairperson of the base FAC.
 - 5.14.2. Serve as the point of contact for the FAP response to press inquiries.
- 5.15. Active Duty Members and Civilian Employees will:
 - 5.15.1. Report all incidents of suspected family maltreatment to the FAP. Exclusions are limited to chaplains receiving information through a "penitent-clergy" relationship or confidential communications in the course of their official duties, and Area Defense Counsel (ADC) receiving information from an established attorney-client relationship.
 - 5.15.2. Every active duty member will notify the SNC when he or she has one or more family members with special educational and/or medical, including psychological, needs.

5.15.3. All active duty members will comply with FMRC screening of family members for PCS travel.

5.16. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

6. Case Management Teams.

6.1. CSMRT.

6.1.1. The purpose of the CSMRT is to establish, upon receipt of a child sexual abuse referral, jurisdiction, and how the organizations involved will proceed in making required notifications, conducting interviews, scheduling medical exams, arranging for safety of all family members and conducting psycho-social assessments. Once jurisdiction is established and an initial plan is formulated, other agencies/organizations may be notified as appropriate. The goal of the team approach is to minimize the trauma to the victim and family, and ensure no one individual or agency makes decisions regarding these incidents independent of the concerns of other involved agencies. The CSMRT facilitates a collaborative effort with interagency involvement. It allows for creative problem solving, joint decision-making, access to the best resources available to military families, and the clarification of roles and responsibilities.

6.1.2. Membership:

6.1.2.1. FAO and/or Family Advocacy Treatment Manager (FATM) (*Coordinator*).

6.1.2.2. AFOSI representative.

6.1.2.3. SJA.

6.1.2.4. Family Advocacy Program Assistant (FAPA) (*Recorder*).

6.1.2.5. If an investigation is primarily conducted by civilian agencies (e.g., Child Protective Services, local law enforcement), they may be invited to participate in the CSMRT.

6.1.2.6. Medical providers are not included on the CSMRT due to judicial considerations (e.g., ability to report spontaneous disclosures in court).

6.1.2.7. CSMRT members should have the authority to make commitments and decisions on behalf of their organizations/agencies. Alternates attending the CSMRT should have the same authority to make commitments and decisions for the agency they represent.

6.1.3. The FAO will report quarterly to the FAC all CSMRT activation's, corresponding FMCMT findings, trainings, and effectiveness of the process.

6.1.4. The CSMRT members and their alternates will meet at least annually to clarify roles and responsibilities. New members will be trained within 90 days of appointment to the CSMRT.

6.1.5. Civilian laws regarding interviews of child victims of sexual maltreatment will be followed.

6.1.6. The SJA may provide, through the VWAP, victim advocates in maltreatment cases.

6.1.7. Unresolved issues are advanced through the FAC, CAIB, Major Command (MAJCOM) FAP Manager, AFMOA/SGZF, or other appropriate channels.

6.1.8. Meets at the call of the Coordinator following the notification of alleged child sexual maltreatment.

6.1.9. Following the notification of alleged child sexual maltreatment, the CSMRT will be activated immediately in order to implement initial action procedures. The initial team meeting will:

6.1.9.1. Review the allegation(s).

6.1.9.2. Coordinate a course of action.

6.1.9.3. Ensure victim safety and prevent re-victimization.

6.1.9.4. Attend to the well being of the victim, the victim's family, and the alleged offender.

6.1.9.5. Ensure suicidal/homicidal risk is evaluated for every at-risk family member.

6.1.9.6. Develop a strategy for interviewing the victim, including location and personnel to conduct the interview.

6.1.9.7. Ensure the number of investigative interviews and medical examinations are minimized to reduce the potential emotional trauma of the investigative process.

6.1.10. The FAO and/or FAP clinician will be the lead coordinator to ensure that the CSMRT is activated upon receipt of child sexual maltreatment referral and once an initial plan is formulated, makes required notifications.

6.1.11. Due to the serious nature of these allegations and the increased likelihood of prosecution, AFOSI or local law enforcement will often be the lead agency in the CSMRT's coordinated course of action. Family Advocacy may be asked to defer the psychosocial assessment interviews until the alleged offender and perhaps the non-offending parent have been interviewed by law enforcement. FAP staff will follow-up with CSMRT to coordinate when the complete FAP psychosocial assessment interviews may be accomplished.

6.1.12. Safety assessments and plans must be accomplished immediately. If CSMRT members disagree about accomplishing safety assessments and plans, the FAO will elevate these concerns to the FAC chairperson immediately.

6.1.13. As a matter of policy, FAP is a partner with AFOSI and SFS as a first responder in maltreatment cases and must be allowed to perform their required functions.

6.2. HRVRT.

6.2.1. The HRVRT will manage the initial response to potentially dangerous situations involving FAP clients and/or FAP staff. The goal of the HRVRT is to use a coordinated community response to decrease the risk of violence. Potentially dangerous situations include threats to seriously harm family members or FAP staff.

6.2.2. Membership:

6.2.2.1. FAO (*Coordinator*).

6.2.2.2. FAP clinician working with the family.

6.2.2.3. Sponsor's Squadron Commander (SQ/CC).

6.2.2.4. SFS Operational Flight Commander.

6.2.2.5. SJA.

6.2.2.6. LSSC Provider.

6.2.2.7. AFOSI representative.

6.2.2.8. FAPA (*Recorder*).

6.2.2.9. Representative(s) from other agencies having legal, investigative, or protective responsibilities as appropriate (e.g., base housing and community shelter).

6.2.2.10. HRVRT members should have the authority to make commitments and decisions on behalf of their organizations/agencies. Alternates attending the HRVRT should have the same authority to make commitments and decisions for the agency they represent.

6.2.3. The FAO and/or FAP clinician will be the lead coordinator to ensure that the HRVRT is notified of potentially dangerous situations.

6.2.3.1. Members of a family unit may be in imminent danger of being harmed by other family members. For the purpose of the HRVRT, family members include active duty, spouses, children and stepchildren, ex-spouses, or ex-stepparents.

6.2.3.2. Staff members may be in imminent danger of being harmed by a family advocacy client or ex-client.

6.2.4. The FAO will ensure that key base leadership (FAO's chain of command/FAC Chairperson/WG Commander) are briefed of HRVRT activation as appropriate.

6.2.5. Meets at the call of the Coordinator.

6.2.6. Unresolved issues are advanced through the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF, or other appropriate channels.

6.2.7. The HRVRT will assess the level of danger, then develop and implement a course of action to manage the risk of violence.

6.2.8. When a high-risk-for-violence situation involves a member of the family unit from another Uniformed Service, FAP staff will provide input to the Service FAP and other units as appropriate to affect Joint Service community safety planning. The other Uniform Service representative will be invited to participate on the HRVRT. When the unit of the other Uniformed Service is not co-located, input on the high-risk-for-violence situation will be provided to their installation FAP and other units as appropriate.

6.2.9. Appointed team members and their alternates will meet at least annually.

6.3. FMCMT.

6.3.1. The purpose of the FMCMT is to clinically manage the assessment of and interventions with families having allegations of maltreatment. Administrative, legal, and disciplinary issues will not be addressed at the FMCMT, except as they pertain to safety issues for clients.

6.3.2. Membership (Two-thirds necessary to form a quorum):

6.3.2.1. FAO (*Chairperson*).

6.3.2.2. FATM.

6.3.2.3. SJA.

6.3.2.4. Physician/Physician Assistant or Nurse Practitioner.

6.3.2.5. Family Member Support Flight Chief (or Youth Center or CDC Director).

6.3.2.6. SFS representative.

6.3.2.7. AFOSI representative.

6.3.2.8. FSC representative.

6.3.2.9. Chaplain representative.

6.3.2.10. FAPA (*Recorder*).

6.3.2.11. FAP clients are not permitted to observe, attend or participate in FMCMT meetings.

6.3.2.12. Membership will contain no more than one-third FAP staff. Any additional FAP staff in attendance will be considered guests and will abstain from voting.

6.3.2.13. By AFOSI policy, the AFOSI representative does not participate in the FMCMT voting process, but is a required member of the FMCMT. Active AFOSI participation in case discussions is essential to effective case management.

6.3.2.14. When a referred family is also involved with the ADAPT or LSSC, it may be appropriate to invite a representative from that organization as a guest for that case presentation.

6.3.2.15. Child Protective Services and local community Domestic Violence Center representative may be invited to attend.

6.3.2.16. Squadron CCs and First Sergeants (CCF) will be invited to the FMCMT as guests to participate only in discussions concerning assigned members of their units. Those attending the FMCMT will be informed of client privacy issues.

6.3.3. All FMCMT members and alternate members will be trained at least annually on their roles and responsibilities regarding the determination review process, the dynamics of family maltreatment and updates of policy issues pertaining to the FAP.

6.3.4. Meets at the call of the FAO, but at least monthly.

6.3.5. Unresolved issues are advanced through the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF, or other appropriate channels.

6.3.6. The FMCMT will:

6.3.6.1. Only discuss information related and pertinent to maltreatment issues such as, the current allegation(s), the family's history of maltreatment, and family dynamics/contextual factors that are linked to maltreatment in the literature, and present in the family.

6.3.6.2. Review and concur/non-concur on the non-opening of "no record opened" cases.

6.3.6.3. Make incident status determinations within 60 days of referral. When insufficient information is available to make a determination, the case will remain in deferred status and will be reviewed monthly until a determination is made. In very unusual circumstances with complex cases, the FMCMT may decide that available information is insufficient to make a determination within the required timelines. These cases are reviewed monthly with active

efforts to resolve any difficulties so that a determination can be made in a timely manner.

6.3.6.4. Make incident status determinations on each incident by first identifying each type of maltreatment alleged. Then determining whether the allegation meets the DoD definition for that type of maltreatment. Document each type of substantiated maltreatment. When an allegation is determined to be unsubstantiated, the FMCMT must then determine whether the case is Unsubstantiated – Did Not Occur or Unsubstantiated – Unresolved.

6.3.6.5. Develop and review an overall intervention strategy, including treatment modalities, for substantiated incidents. Primary and secondary prevention programs will not be used in lieu of treatment.

6.3.6.6. Ensure unit commanders receive a disposition letter on each case that states the incident status determination and recommendations for intervention. Squadron disposition letters contain confidential, sensitive medical information. As such, these letters must be addressed to the appropriate squadron representative. Letters regarding an officer's FAP case will be addressed to the CC's and envelopes labeled "Eyes Only." Letters regarding enlisted personnel will be addressed to the CC and CCF and envelopes labeled "Eyes Only." Commanders should also receive verbal updates regarding the family's participation in treatment.

6.3.6.7. Make case transfer and closure decisions.

6.3.6.8. Ensure involved adult family members receive notification of FMCMT incident status determination and changes in treatment recommendations. FASOR generates a commander letter that is shared with the sponsor and a copy of the letter will be mailed to spouse's residence.

6.3.6.9. Review each open, substantiated incident at least quarterly, with the exception of child sexual maltreatment incidents, which are reviewed monthly.

6.3.6.10. Refer to the FAC maltreatment cases and issues requiring action beyond the scope of the FMCMT.

6.3.7. In making a determination, recantation by the victim will not, in and of itself, be used to conclude that the incident did not occur.

6.3.8. When making an incident status determination (ISD) on a spouse maltreatment allegation, the FMCMT will ensure that contextual factors and classic dynamics of spouse abuse are thoroughly assessed by the FAP provider and presented to the FMCMT in detail. It is imperative that every effort is made to determine whether there is a history of physical or verbal aggression by one spouse or a significant imbalance or abuse of power in the relationship. As such, more emphasis is placed on the relationship dynamics than any other factor in making these determinations. Every act of aggression does not connote spouse maltreatment. FMCMTs will not label spouse maltreatment victims "offenders."

6.3.9. At the discretion of the FAO, an incident may be brought back before the FMCMT, after the original case status determination is made. If new information becomes available that might have resulted in a different original case status determination that information may be presented at the next FMCMT and a new case status determination may occur.

6.3.10. When requested by FAP clients, and such request is approved by the FAC Chairperson; the FMCMT will review the incident status determination IAW FAP Standard M-9 (refer to paragraph 5.24.3.1.9. for additional details).

6.3.11. Family Advocacy Staff Training (FAST) course:

6.3.11.1. The FAO will:

6.3.11.1.1. Request nominations from the FAC, CSMRT, HRVRT and FMCMT members, as well as from CCs and CCFs, for the FAST course.

6.3.11.1.2. Provide details regarding the projected course(s).

6.3.11.1.3. Forward the nominations to the MAJCOM FAP manager and AFMOA/SGZF by deadlines.

6.3.11.1.4. Report nominations and status to the FAC

6.3.11.1.5. Elevate any concerns in this process to the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF, or other appropriate channels, as needed.

6.3.11.2. FAC, CSMRT, HRVRT and FMCMT members, CCs and CCFs will:

6.3.11.2.1. Consider the FAST course as an opportunity for learning additional skills and knowledge regarding working with families involved in the FAP process.

6.3.11.2.2. Consider primary and alternate staff for the course(s).

6.3.11.2.3. Inform the FAO of interest and nominations in the course before the deadline.

6.3.11.3. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

7. Community Collaboration.

7.1. CAIB.

7.1.1. The CAIB is a mechanism to ensure teamwork, coordination and the appropriate exchange of information on activities among all installation agencies.

7.1.2. The FAO, or appointed alternate, will attend as the FAC subcommittee representative.

7.1.3. The FAOM will attend as the primary FAP IDS representative, with the FAO as the alternate

7.1.4. The FAO and FAOM will:

7.1.4.1. Ensure that necessary information from the CAIB is brought back to the FAP staff.

7.1.4.2. Ensure all reports, metrics and supporting documentation reported as part of the Wing Climate Assessment Committee or elevated from the FAC subcommittee are timely and accurate.

7.1.4.3. Provide input, expertise and participate, as appropriate.

7.1.4.4. Present family maltreatment prevention issues, information and community recommendations.

7.1.4.5. Update any open items.

7.1.4.6. Share the Executive Director duties IAW rotation schedule and detailed in position continuity binder.

7.2. Reference AFI 90-501, *Community Action Information Board and Integrated Delivery System*, 15 October 2002 for additional details and duties.

7.3. IDS.

7.3.1. The IDS team operates from a strength-focused approach, building on the protective factors in the community to enhance community capacity and resilience. The objective of the IDS is to build collaborations and partnerships between leadership, agencies and the community to achieve community results that yield safety, health, wellness, family adaptation, personnel preparedness, and a sense of community.

7.3.2. The FAOM will serve as the primary FAP representative for the IDS, with the FAO as the alternate. The FAP representative to the IDS will:

7.3.2.1. Update any open items.

7.3.2.2. Provide input, expertise and participate, as appropriate.

7.3.2.3. Present family maltreatment prevention issues, information and community recommendations.

7.3.2.4. Present reports, metrics and supporting documentation as needed.

7.3.2.5. Contribute to the development and implementation of the Community Capacity Action Plan (CCAP), which is the annual plan for community prevention operations and goals developed by the IDS.

7.3.2.6. Provide quarterly report for CCAP.

7.3.2.7. Participate in Community Needs Assessment.

7.3.2.8. Be the link between FAP prevention and community partnerships.

7.3.2.9. Ensure the development and delivery of FAP prevention services support installation IDS shared-mission activities, initiatives, and collaborative partnerships.

7.3.2.10. Contribute updated information to the IDS centralized Information and Referral (I&R) database.

7.3.2.11. Facilitate in Suicide Prevention training.

7.3.2.12. Report IDS findings, plans, and initiatives to the FAP staff.

7.3.2.13. Train FAP staff on guidance described in AFI 90-501.

7.3.2.14. Facilitate additional duties as outlined in AFI 90-501.

7.3.2.15. Share the Coordinator duties IAW rotation schedule and detailed in position continuity binder.

7.4. Quarterly AW/CC and FAO meeting.

7.4.1. The Installation CC will meet with the FAO, at least quarterly, to staff trends with high-risk FAP cases.

7.4.2. The FAC Chairperson will ensure procedures for the quarterly brief are developed with the FAO.

7.4.3. The FAO will:

7.4.3.1. Schedule the meeting.

7.4.3.2. Prepare slides and other presentations as appropriate.

7.4.3.3. Pre-brief the FAC Chairperson.

7.4.3.4. Ensure the FAC Chairperson and AW/CV's schedules are blocked for the meeting, as requested.

7.4.3.5. Respond to any requests or feedback provided during the meeting.

7.4.3.6. Elevate these and any unresolved issues to the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF, or other appropriate channels, as needed.

7.4.3.7. Ensure documentation of this meeting is included in the FAC minutes.

7.5. Wing Stand-up.

7.5.1. The FAO will provide information regarding up-coming FAP events and opportunities to the installation leadership at least monthly via the Medical Operations Squadron (MDOS) CC, MTF/CC, other FAP staff member, or in person.

7.5.2. The FAO will ensure that presented information is accurate, timely and in the approved installation format.

7.5.3. The FAO will ensure that appropriate chain-of-command are pre-briefed on materials and any unresolved issues.

7.6. Required training.

7.6.1. Categories.

7.6.1.1. Annual.

7.6.1.1.1. FAC.

7.6.1.1.1.1. The FAO will ensure FAC members are trained, at least annually, on committee roles, responsibilities, and the overall FAP mission.

7.6.1.1.1.2. Training will be documented in the FAC minutes.

7.6.1.1.2. FMCMT.

7.6.1.1.2.1. The FAO will ensure that members are trained on their committee roles and responsibilities, and the overall mission of the committee.

7.6.1.1.2.2. Training will be documented in the FMCMT and FAC minutes.

7.6.1.1.3. HRVRT

7.6.1.1.3.1. The FAO will ensure that members are trained on their committee roles and responsibilities, and the overall mission of the committee.

7.6.1.1.3.2. Training will be documented in the HRVRT and FAC minutes.

7.6.1.1.4. CSMRT

7.6.1.1.4.1. The FAO will ensure that members are trained on their committee roles and responsibilities, and the overall mission of the committee.

7.6.1.1.4.2. Training will be documented in the CSMRT and FAC minutes.

7.6.1.1.5. Family violence education and prevention training

7.6.1.1.5.1. Personnel and agencies:

7.6.1.1.5.1.1. Medical providers and support staff

7.6.1.1.5.1.2. Legal

7.6.1.1.5.1.3. Security Forces

7.6.1.1.5.1.4. AFOSI detachment

7.6.1.1.5.1.5. FSC

7.6.1.1.5.1.6. Family Child Care providers (Home and CDC)

7.6.1.1.5.1.7. Youth Center

7.6.1.1.5.1.8. IDS

7.6.1.1.5.1.9. CAIB via IDS

7.6.1.1.5.2. Areas to cover

7.6.1.1.5.2.1. Family violence education and prevention training will promote sensitivity to family violence issues and advocating for nonviolent communities.

7.6.1.1.5.2.2. Training will focus on leadership, active duty, provider and community member responsibilities in prevention, including community organization approaches in prevention, early identification, reporting and referral.

7.6.1.1.5.2.3. Training will include the core training requirements mandated by AFMOA/SGZF.

7.6.1.1.5.2.4. Training will occur for all new personnel and annually thereafter.

7.6.1.1.6. New Commanders and First Sergeants (CC/CCF)

7.6.1.1.6.1. New CC/CCF will receive ongoing FAP orientation within 60 days of CAFB arrival.

7.6.1.1.6.2. All CC/CCF will receive annual Family Violence Education and Prevention training within 180 days of the fiscal year.

7.6.1.1.6.3. Orientations and annual trainings must be accomplished in person.

7.6.1.1.7. Other personnel, family members, and volunteers, will be provided a minimum of one training annually.

7.6.1.2. Other agencies and the community at large, receive education and training as appropriate and/or as requested.

7.6.2. Facilitation

7.6.2.1. The FAO will be the primary trainer for the FAC, FMCMT, HRVRT and CSMRT.

7.6.2.2. The FAOM will be the key facilitator in organizing/providing family violence education/prevention training.

7.6.2.3. FAP staff will participate in annual training as requested by the FAOM and approved by the FAO.

7.6.3. The FAOM will ensure training covers required areas and is targeted toward the audience.

7.6.4. The FAO and FAPA will ensure this training status is recorded in the FAC minutes.

7.6.5. The FAOM will ensure the training is recorded in the FAP Outreach Prevention Log.

7.6.6. The FAOM will present the status of required training to the FAC.

7.6.7. The FAO will ensure all FAP staff consult with the FAO, FAC Chairperson and installation Public Affairs Office on all news articles, interviews, public statements for air or print or other public relations issues that may be sensitive for the AF or have implications beyond the local installation.

7.6.8. The FAP marketing plan will be coordinated with the IDS and linked with IDS marketing strategies.

7.6.9. The FAOM will implement community organization strategies in collaboration with the IDS and other key organizations and stakeholders to increase awareness of family maltreatment, promote the family awareness program, develop a collaborative plan for reducing risk factors within the community, identifying community strengths and facilitating program and community results that foster and promote community resiliency.

7.7. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

8. Maltreatment Referral Procedures.

8.1. Family maltreatment in the Air Force is categorized by the definitions outlined in [Attachment 1](#).

8.2. Responsibilities:

8.2.1. All military, DoD, civilian, and family members assigned, attached, in transit, or visiting CAFB will notify the FAP staff immediately with suspicions and/or evidence of family maltreatment when there are concerns for:

8.2.1.1. Maltreatment of any type to a child (military beneficiary of active duty) by a caretaker within the family.

8.2.1.2. Sexual maltreatment of a child (military beneficiary of active duty) by a caretaker or person in a position of power over the child, including in a Department of Defense-sanctioned activity (any location where the military has sanctioned or authorized care of children by individuals other than their legal guardians).

8.2.1.3. Physical or emotional maltreatment or neglect to a child (military beneficiary of active duty) by an extra-familial caretaker, including DoD-sanctioned provider.

8.2.1.4. Maltreatment of an individual by his/her spouse where one or both are active duty (does not include cohabiting partners or dating relationships).

8.2.1.5. Child or spouse maltreatment of retiree family members.

8.2.1.6. All other maltreatment incidents should be handled through other notification matrix (SFS, OSI, etc.).

8.2.2. Regardless if during duty hours or after duty hours, CAFB personnel will contact FAP staff immediately in the Family Advocacy office or by paging the on-call Behavioral Science provider (current listing maintained at the SFS Law Enforcement desk, Command Post and MTF Group Control Center).

8.2.3. The FAP staff will notify the AW/CC MTF/CC, MDOS/CC, Chief of Clinical Staff (MDG/SGH), sponsor's CC and/or CCF, Security Forces Squadron (SFS), SJA, Detachment agent in the AFOSI, Child Protective Services (CPS), LSSC or other investigative or protective agency, as appropriate/needed.

8.2.3.1. The MTF/CC, MDOS/CC and/or MDG/SGH should be informed in every severe or complicated maltreatment case, or when there is discussion of a maltreatment admission to, or delay of discharge from, the MTF due to family maltreatment.

8.2.3.2. The Family Advocacy Officer (FAO) will make recommendations to the MTF/CC in situations where a FACAT may be needed.

8.2.3.2.1. In cases of multiple-victim child sexual maltreatment in DoD-sanctioned activities, the CSMRT and the FAC will consider recommending that the installation commander request deployment of the DoD FACAT.

8.2.3.2.2. The purpose of the FACAT is to improve the response to possible child sexual maltreatment situations in DoD-sanctioned activities.

8.2.3.2.2.1. The FACAT is organized as a coordinated, Joint-Service evaluation team, operating as a Headquarters-level task force, to ensure open lines of communication and provide expert consultation/participation PRN.

8.2.3.2.2.2. The FACAT is comprised of Joint-Service specialists in psychology, psychiatry, criminal investigations, pediatric medicine, clinical social work, public affairs, and criminal law who are trained to respond to complex cases.

8.2.3.2.2.3. While deployed to a base, the FACAT reports to the installation commander.

8.2.3.2.2.4. Effective working relationships will facilitate the continuity of investigative and treatment efforts following FACAT departure.

8.2.3.3. The FAP will ensure the CSMRT and/or HRVRT is activated PRN.

8.2.3.4. In cases of death due to maltreatment, the following local procedures will be followed:

8.2.3.4.1. Inform the FAO immediately, who will brief the MTF/CC and then the AW/CC.

8.2.3.4.2. Immediately notify the Command Post.

8.2.3.4.3. Inform the AFOSI immediately and obtain the AFOSI case number.

8.2.3.4.4. Immediately notify the Charleston County CPS.

8.2.3.4.5. The FAO is responsible for dissemination of all coordination with Public Affairs and AFMOA/SGZF.

8.2.3.4.6. The FAO is responsible for completing and disseminating the High Interest Incident Worksheet to the AFMOA/SGZF and the MAJCOM FAP Manager.

8.2.3.4.7. Assistance is available from OSI forensic consultants and the Armed Forces Center for Child Protection, National Navy Medical Center, Bethesda, MD for medical consultation in cases of severe/fatal child maltreatment. AFMOA/SGZF director, deputy director, or treatment program manager can also provide consultation and management of these complex cases.

8.3. Procedures:

8.3.1. Upon identification of a family member who has or is suspicious to have been maltreated:

8.3.1.1. FAP staff will:

8.3.1.1.1. Obtain necessary referral information.

8.3.1.1.2. Forward the FAP referral form to the SFS/SFOSI representative.

8.3.1.1.3. Forward the FAP referral form to the AFOSI detachment representative.

8.3.1.1.4. Forward the referral information to the respective county's CPS, in all alleged child maltreatment referrals.

8.3.1.1.5. Notify the sponsor's CC/CCF.

8.3.1.1.6. Make additional notifications, as noted above.

8.3.1.1.7. Ensure appointments for needed medical assessments are made in a timely manner.

8.3.1.1.8. Ensure assessments are arranged to increase safety of all involved family members and decrease potential for coaching/coercion or further threat of harm.

8.3.1.1.9. Ensure appropriate transportation arrangements are coordinated, including:

8.3.1.1.9.1. Alleged child/spouse victims needing transportation to a medical exam or interview are transported by the alleged offender (or non-offending parent) only when they are escorted by the CCF (or another squadron representative appointed by the CC/CCF) and both the alleged offender and escort have been directed not to discuss the injuries/allegations with the alleged victim or in the presence of the alleged victim prior to the FAP, or other approved, interview.

8.3.1.1.9.2. When transportation is necessary for a FAP client needing medical assistance, including emotional, and other arrangements (including CCF, co-worker, family, neighbor, etc) are not available or appropriate, Rural Metro will be contacted.

8.3.1.1.9.2.1. Rural Metro will transport individuals to local hospitals/assessment centers.

8.3.1.1.9.2.2. Rural Metro charges the cost of transportation to the individual's insurance or they have to pay up-front (if insurance is not an option).

8.3.1.1.9.2.3. Rural Metro requires that individuals being transported agree to do

so voluntarily.

8.3.1.1.10. Ensure pictures are taken when there is suspected evidence of maltreatment.

8.3.1.1.10.1. Coordinate with the SF Law Enforcement Desk who will contact the on-call Alert Photographer.

8.3.1.1.10.2. If the Alert Photographer has not arrived by the time the evaluation/interview is ready to begin, the interviewer/evaluator will contact SFS directly at extension 3600 to ensure the Alert Photographer is on their way.

8.3.1.1.11. An initial risk (safety) assessment by a FAP staff member will occur immediately upon receipt of a referral of alleged family maltreatment.

8.3.1.1.11.1. When a mental status exam (MSE) is needed for a FAP client (active duty or civilian) suspected to be at risk to themselves or others, the MSE will occur by:

8.3.1.1.11.1.1. A FAP staff member will provide the MSE, with consultation as needed.

8.3.1.1.11.1.2. A Behavioral Sciences provider will complete the MSE, with consultation as needed.

8.3.1.1.11.2. If a civilian family member does not choose to come to the FAP office or the LSSC and they are considered:

8.3.1.1.11.2.1. Not in imminent danger, they may be referred to an outside mental health provider through TRICARE (Choice Behavioral), their personal insurance, county mental health office, or out-of-pocket.

8.3.1.1.11.2.2. In imminent danger, Mobile Crisis will be contacted for assessment and potential transport (the FAP office has the current contact information).

8.3.1.1.11.3. Active duty may be directed to the FAP or LSSC for a safety assessment.

8.3.1.1.11.4. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

8.3.1.1.12. Intake assessments will be initiated within three duty days or sooner if risk requires.

8.3.1.1.13. Consider an active duty client's fitness for duty.

8.3.1.1.14. Ensure appropriate safety and intervention plans are initiated with families.

8.3.1.1.15. Ensure sponsor's CC/CCF's are kept informed of status and plans for proceeding with the family.

8.3.1.1.16. Staff all referrals at the FMCMT.

8.3.1.1.17. Ensure sponsors and their CC/CCF are informed of the FMCMT Incident Status Determination (ISD) and recommended intervention plan.

8.3.1.2. SFS will:

8.3.1.2.1. SFS LE desk will:

8.3.1.2.1.1. Provide patrol response to suspected incidents of family maltreatment

occurring on CAFB

8.3.1.2.1.2. Security Forces officers responding to reported incidents of family maltreatment will secure the safety of all individuals involved.

8.3.1.2.1.3. Security Forces officers responding to reported incidents of family maltreatment may consult with the FAP staff or on-call Behavioral Sciences Flight provider to receive assistance in dealing with abusive or neglecting families.

8.3.1.2.1.4. Notify Charleston County police/sheriff's department in all cases of suspected child and spouse maltreatment where a civilian is involved.

8.3.1.2.1.5. Notify the CCF in all cases of suspected child and spouse maltreatment.

8.3.1.2.1.6. Notify the FAP of all suspected child and spouse maltreatment incidents during the duty day by calling extension 6972, after-hours by calling the on-call Behavioral Sciences Flight provider when a domestic incident occurs and the AFOSI is called, a child is involved in anyway (as a witness or a victim), or for consultation, and by forwarding the blotter each duty day to the FAPA.

8.3.1.2.2. SFS gate guards will:

8.3.1.2.2.1. Verify presenting CPS caseworkers' name is on the Entry Authority Listing (EAL), which the FAP will provide. The FAO will ensure updated lists are forwarded in a timely manner.

8.3.1.2.2.2. Issue a visitor's pass to the CPS caseworker.

8.3.1.2.2.3. Be on the lookout (BOLO) for alleged offenders and their vehicles when requested.

8.3.1.2.2.3.1. The FAO will coordinate FAP client entries to the BOLO listing through the respective CSMRT, FMCMT or HRVRT SFS representative, when needed.

8.3.1.2.2.3.2. This representative will ensure the listing is added and deleted in a timely manner, when requested.

8.3.1.2.2.4. Prevent individuals barred from the base from entering CAFB.

8.3.1.2.2.4.1. The FAO will draft a barment request letter when individuals believed to be at risk for harming FA clients cannot be maintained by other means.

8.3.1.2.2.4.2. The FAO will coordinate this letter through the respective CSMRT, FMCMT or HRVRT SFS representative.

8.3.1.2.2.4.3. The FAO will pre-brief and provide the request letter to the FAC Chairperson for approval and coordination.

8.3.1.2.2.4.4. The FAO will ensure that the SFS representative forwards the approved request letter to the Mission Support Group Commander and/or the AW/CC for approval in a timely manner.

8.3.1.2.2.4.5. SFS will ensure that a copy of the letter is sent to the barred individual and maintained as needed.

8.3.1.2.2.4.6. SFS will ensure that the barmnet is retracted when authorized.

8.3.1.2.3. SFS/SFOSI will:

8.3.1.2.3.1. Receive referrals from the FAP.

8.3.1.2.3.2. Report suspicions of family maltreatment to the FAP in a timely manner.

8.3.1.2.3.3. Lead investigative interviews with alleged extra-familial offenders.

8.3.1.2.3.3.1. In cases where the suspected family maltreatment occurred in a DoD-sanctioned activity and the alleged offender is an extra-familial caretaker, the director/CC of that activity will:

8.3.1.2.3.3.1.1. Notify the FAP with referral information.

8.3.1.2.3.3.1.2. Notify the Department of Social Services, Division of Out of Home Abuse and Neglect (OHAN) component in Columbia, SC (current number maintained in the FAP) with referral information.

8.3.1.2.3.3.1.3. Make other administrative notifications and determinations/actions as appropriate and authorized, including removing the suspected caretaker from that position until a safety assessment/investigative interview can be conducted.

8.3.1.2.3.3.2. The FAP staff will:

8.3.1.2.3.3.2.1. Notify the SFS/SFOSI, or in cases of alleged child sexual maltreatment, the AFOSI detachment agent.

8.3.1.2.3.3.2.2. Coordinate response of investigations amongst installation and community agencies.

8.3.1.2.3.3.2.3. Not conduct investigative interviews with alleged extra-familial offenders.

8.3.1.2.3.3.2.4. Staff the referral at the FMCMT.

8.3.1.2.3.3.2.5. Coordinate recommended interventions through the community, or FAP if they are also military beneficiaries.

8.3.1.2.3.3.2.6. Treatment for sexual maltreatment will not be provided through the FAP, nor funded through MTF-funds; however, outreach and prevention classes/groups are open to all military beneficiaries.

8.3.1.2.3.3.3. Investigative agencies (OSI, SFS, and CPS/OHAN) will conduct all investigative interviews with alleged extra-familial offenders and make recommendations to the FMCMT and the director/CC of the DoD-sanctioned activity.

8.3.1.2.3.4. Provide the FAP with timely information (including DD Form 1569, Incident/Complaint Report) concerning all incidents or complaints of family maltreatment.

8.3.1.2.3.5. Support investigative interviews of alleged criminal offenders in cases occurring in DoD-sanctioned activities, where there are no rules violations.

8.3.1.2.3.6. Serve as a representative to the FMCMT and HRVRT.

- 8.3.1.2.3.7. Coordinate investigations of child and spouse maltreatment with AFOSI
- 8.3.1.2.3.8. Collaborate with the FAP on investigations, and provide information to the FMCMT and HRVRT as possible.
- 8.3.1.2.3.9. Update the FAP staff of any changes/concerns/questions regarding FAP families.
- 8.3.1.2.3.10. Advise the alleged offender of Article 31(b) rights.
- 8.3.1.2.3.11. Coordinate and monitor child and spouse maltreatment investigations conducted by civilian agencies.

8.3.1.3. AFOSI detachment agent will:

- 8.3.1.3.1. Serve on the FMCMT, CSMRT, and HRVRT.
- 8.3.1.3.2. Report all allegations/suspicious of family maltreatment to the FAP.
- 8.3.1.3.3. Search the DCII and its internal database for historical data pertaining to all reported incidents of child maltreatment, and on serious spouse maltreatment, and provide this information to the FAP.
- 8.3.1.3.4. Lead investigations regarding aggravated assaults, sexual assaults, and all incidents of child sexual maltreatment.
- 8.3.1.3.5. Coordinate and monitor child and spouse maltreatment investigations conducted by civilian agencies.
- 8.3.1.3.6. Collaborate with the FAP on investigations, and provide information to the FMCMT, CSMRT and HRVRT as possible.
- 8.3.1.3.7. Update the FAP staff of any changes/concerns/questions regarding FAP families.
- 8.3.1.3.8. Advise the alleged offender of Article 31(b) rights.
- 8.3.1.3.9. Investigate family maltreatment involving the infliction of serious bodily harm. These cases are evaluated on a case-by-case basis depending on the circumstances of each incident.
- 8.3.1.3.10. Investigate all reports of rape, sexual assault, indecent assault, sodomy, carnal knowledge, and child sexual assault. Depending on individuals involved, AFOSI may assume control of the investigation, work a joint investigation with the local police, and/or monitor the local police investigation, evaluated on a case-by-case basis.

8.3.1.4. Medical personnel will:

- 8.3.1.4.1. Provide for the necessary medical treatment and documentation of the injuries, written and with pictures when indicated.
- 8.3.1.4.2. Make sure the patient is medically stable, with immediate transport directly to the nearest emergency room if the injury is severe or life threatening.
- 8.3.1.4.3. Report all suspicions of family maltreatment to the FAP.
- 8.3.1.4.4. Update the FAP staff of any changes/concerns/questions regarding FAP fami-

lies.

8.3.1.4.5. Refer to the 437th Medical Group Instruction 40-07, *Family Advocacy Notification/Assessment Procedures*.

8.3.1.5. SJA staff will:

8.3.1.5.1. Report all suspicions of family maltreatment to the FAP as possible. Exclusions are limited to ADC receiving information from an established attorney-client relationship.

8.3.1.5.2. Serve on the FMCMT, CSMRT, and HRVRT.

8.3.1.5.3. Provide information about legal rights of family members in the FAP.

8.3.1.5.4. Provide consultation services to the FAP.

8.3.1.5.5. Coordinate with the FAO to ensure ready availability and effectiveness of VWAP services for qualifying families.

8.3.1.5.6. Update the FAP staff of any changes/concerns/questions regarding FAP families.

8.3.1.5.7. Advise the alleged offender of Article 31(b) rights.

8.3.1.6. CC/CCFs will:

8.3.1.6.1. Report all suspicions of family maltreatment to the FAP.

8.3.1.6.2. Direct suspected AD family maltreatment offenders to the FAP.

8.3.1.6.3. Provide information and referral to AD members and eligible beneficiaries on the FAP prevention and maltreatment intervention services.

8.3.1.6.4. Work with the FAP staff to ensure safety plans are worked with families, including issuing no-contact orders to allow for cooling-off periods and intervention plans to be established.

8.3.1.6.5. Update the FAP staff of any changes/concerns/questions regarding FAP families.

8.3.1.6.6. Support families receiving FAP services and interventions.

8.3.1.6.7. Consult with FAP staff during or after duty hours, as needed, regarding the status/concerns for FAP families.

8.3.1.6.8. Ensure the FAP is aware of any FA-related response to a sponsor's residence, at least by the next duty day if it occurs after hours, or within the same day if during duty hours, and as safety necessitates.

8.3.1.7. FAC Chairperson will:

8.3.1.7.1. Coordinate with other group and squadron commanders to resolve concerns and questions regarding FAP families/services.

8.3.1.7.2. Brief the AW/CC on any severe, complicated or unresolved cases of alleged family maltreatment, including child sexual maltreatment and death due to maltreatment.

8.3.1.7.3. Consider activating the FACAT when there are suspicions of multi-victim child sexual maltreatment in a DoD-sanctioned activity.

8.3.1.8. AW/CC will:

8.3.1.8.1. Coordinate with group and squadron commanders to resolve concerns and questions regarding FAP families/services.

8.3.1.8.2. Consider activating the FACAT when there are suspicions of multi-victim child sexual maltreatment in a DoD-sanctioned activity.

8.3.1.8.3. Support families receiving FAP services and interventions.

8.3.1.9. Lodging staff will:

8.3.1.9.1. Coordinate with CC/CCFs and FAP staff regarding temporary lodging for alleged victims when needed, as part of developed safety plans with families.

8.3.1.9.1.1. CC/CCF or FAP staff will reserve a room for the alleged victim(s) under an alias.

8.3.1.9.1.2. Lodging staff will ensure information regarding alleged victim(s) is not released to any unauthorized individual(s).

8.3.1.9.1.3. The CC/CCF or FAP staff will pick up lodging key and ensure alleged victim(s) get to reserved room and understand safety plan, including any authorized no-contact order.

8.3.1.9.1.4. The CC/CCF will ensure the alleged offender, sponsor, et cetera pay for the room at least by check-out.

8.3.1.9.2. Any discrepancies or concerns with this plan will be elevated to the FAO, who will raise it to the FAC Chairperson and others, as appropriate.

8.3.1.10. Incident Status Determination Review (ISDR):

8.3.1.10.1. The ISDR process enables FAP clients to have their FMCMT-determined cases reviewed if they can show additional information is available that was not available at original ISD and/or FMCMT procedures were not adequately followed.

8.3.1.10.2. The FAC Chairperson will designate, in writing, two members of the Family Advocacy Committee (FAC) to serve one-year appointments as the ISDR Process Reviewer and alternate.

8.3.1.10.3. Any FAP case, including unsubstantiated cases, may be reviewed, when criteria for review are met.

8.3.1.10.3.1. An alleged offender or victim must submit the ISDR request to the FAC Chairperson within 30 days of being notified of the FMCMT case status determination.

8.3.1.10.3.1.1. Requests for ISDRs received in excess of 30 days may be considered when extenuating circumstances preclude timely submission.

8.3.1.10.3.1.2. When the client's request for ISDR is received after the 30-day period for requesting ISDR (in the absence of extenuating circumstances), or if the original case status determination was made prior to July 1998; the client has two options available:

8.3.1.10.3.1.2.1. The client may file an Inspector General (IG) complaint or

8.3.1.10.3.1.2.2. The client may contact the AF Board for Correction of Military Records IAW AFI 36-2603, *Air Force Board for Corrections of Military Records*, 1 March 1996.

8.3.1.10.3.2. The FAC Chairperson receives the client's request for ISDR and makes two copies of the request, forwarding one to the ISDR Process Reviewer and one to the FAO.

8.3.1.10.3.2.1. All three thoroughly review the ISDR Request.

8.3.1.10.3.2.2. The FAO and ISDR Process Reviewer make recommendations to the FAC Chairperson as to whether or not the request appears to meet one or both criteria required for the ISDR Review.

8.3.1.10.3.2.3. The FAO will document this meeting, recommendations and decision in the FAP Record.

8.3.1.10.3.2.4. The ISDR Process Reviewer is not subject to interview by the FAP client.

8.3.1.10.3.2.5. The FAC Chairperson makes the final determination as to whether the ISDR meets the criteria for review, specifically:

8.3.1.10.3.2.5.1. New information that could effect the determination that was not available to the FMCMT at the time of the original determination and/or

8.3.1.10.3.2.5.2. Concerns about the FMCMT's compliance with published protocols and requirements.

8.3.1.10.3.3. If the FAC Chairperson determines the ISDR request does not meet the required criteria, a letter is sent to the client denying the ISDR request, with a courtesy copy to the sponsor's commander and the FAO.

8.3.1.10.3.4. If the FAC Chairperson determines the ISDR request does meet the required criteria; the case is scheduled for review at the next FMCMT meeting.

8.3.1.10.3.4.1. The FAC Chairperson will chair the FMCMT only for that case presentation, IAW established FMCMT processes.

8.3.1.10.3.4.2. The FAC Process Reviewer will observe the ISDR process.

8.3.1.10.3.4.3. The FAP provider who conducted the family's assessment will present the incident summary.

8.3.1.10.3.4.4. The FAC Chairperson will present the client's ISDR request and lead the subsequent discussion resulting in the ISDR decision.

8.3.1.10.3.5. The FAO will draft the letter to the client, with notification of the ISDR case status determination, and forward it to the FAC Chairperson for review, approval and signature. A courtesy copy will be forwarded to the sponsor's commander and FAP for entry into the FAP record. A copy of the "official" response to the client will be placed in the respective FAP Record.

8.3.1.10.3.6. Within 30 days of the client's notification of the results of the ISDR, the client may request an AFMOA/SGZF-level ISDR. If the FAC Chairperson denied the

client's ISDR request, the AFMOA/SGZF-level review is not an option.

8.3.1.10.3.7. Changes in the incident status determination because of the ISDR will be noted in the appropriate family members' outpatient medical record (OPMR). Notes in the outpatient medical record from previous FMCMTs cannot be removed. If a change in status has been made because of an ISDR, and the client wants the corrected note documenting the previous case status determination removed, they must contact the Board of Corrections of Military Records.

8.3.1.10.3.8. ISDR results will be briefed to the FAC and reflected in the FAC minutes.

8.4. Maltreatment Evaluations by non-FAP staff:

8.4.1. Evaluations for family maltreatment will be conducted by:

8.4.1.1. MTF Medical personnel for initial assessments, stabilization and documentation of suspected maltreatment.

8.4.1.2. Community comprehensive maltreatment assessment centers (refer to established MOUs with these agencies-maintained in the FAP office).

8.4.1.3. These centers' evaluations will include interview with a child psychologist, medical examination for all types of maltreatment and documentation of findings and recommendations, as appropriate.

8.4.2. The respective County CPS and/or FAP staff will coordinate such assessments.

8.4.3. Information gathered will be shared amongst investigative and protective agencies IAW current MOUs with these agencies.

8.4.4. Multi-disciplinary teams from the involved agencies will gather to discuss the findings and plan for proceeding, as indicated.

8.4.5. The FAO will elevate any concerns or discrepancies in MOUs with the above agencies to their Directors, the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF or other office as appropriate.

8.5. Inter-service Coordination:

8.5.1. When allegations of maltreatment occur in families of other services or joint services, coordination of assessment and intervention will occur IAW established ISSAs:

8.5.1.1. If the family has a parent that is active duty and:

8.5.1.1.1. In the Air Force, but assigned to another base:

8.5.1.1.1.1. The CAFB FAO will notify the other base's FAO or FATM, who will collaborate on coordination of assessment, case staffing at FMCMT, and intervention provision based on the situation.

8.5.1.1.2. In another service:

8.5.1.1.2.1. If the other service has a local FAP office, the CAFB FAO will notify the other service's FAP office staff, who will resume case management and intervention, as appropriate.

8.5.1.1.2.2. If the other service does not have a local FAP office, the CAFB FAO will

notify the other service's FAP office director staff, to coordinate assessment, case staffing, and intervention provision based on the situation.

8.5.1.1.3. Is married to another active duty member in another service:

8.5.1.1.3.1. The CAFB FAO staff will notify the other service's FAP director to discuss coordination of assessment, case staffing at FMCMT, and intervention provision.

8.5.1.2. Where the CAFB FAP maintains assessment and/or case staffing, the CAFB FAP staff will ensure the respective service's central registry receives notification of substantiated family maltreatment incidents.

8.5.1.3. Where the CAFB FAP maintains assessment, intervention provision, and/or case staffing, the CAFB FAP staff will ensure that the sponsor's CC/CCF is made aware and kept informed of status and plans for proceeding with the family.

8.5.2. The CAFB FAO will elevate any concerns or discrepancies in ISSAs with the above FAPs to the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF or other office as appropriate.

8.6. Geographically Separated Units (GSU) collaboration:

8.6.1. Where there is a suspicion of family maltreatment:

8.6.1.1. The CAFB FAP staff will:

8.6.1.1.1. Work with the sponsor's CC/CCF to obtain accurate information and plan for the safety/well-being of the family.

8.6.1.1.2. Work with the respective County's CPS to obtain information and plan for the safety/well-being of the family.

8.6.1.1.3. Work with the CAFB SFS/SFOSI and OSI, as appropriate, to obtain information and plan for the safety/well-being of the family with the respective local civilian law enforcement agencies.

8.6.1.1.4. Assess clients telephonically and/or coordinate for their temporary duty assignment (TDY) to CAFB for in-person assessments, as needed.

8.6.1.1.5. Receive collateral information telephonically or in-writing (i.e. fax, email, mail).

8.6.1.1.6. Staff findings at the FMCMT and make recommendations for intervention.

8.6.1.1.7. As appropriate coordinate intervention in the family's local area, through CPS or TRICARE authorization.

8.6.1.1.8. Offer services at the CAFB FAP as requested and appropriate for the specific needs of the family.

8.6.1.2. The SFS/SFOSI and OSI staff will:

8.6.1.2.1. Provide coordination and consultation with the respective local civilian investigative agencies.

8.6.1.2.2. Conduct investigations as authorized.

8.6.1.2.3. Forward this information to the FAP in a timely manner.

8.6.1.3. The JA staff will:

8.6.1.3.1. Provide consultation to the FAP clients, as requested and appropriate.

8.6.1.3.2. Provide legal services to the FAP clients, as requested and appropriate.

8.6.2. The CAFB FAO will elevate any concerns or discrepancies with the above plan to the FAC, CAIB, MAJCOM FAP Manager, AFMOA/SGZF or other office as appropriate.

8.7. Conflict of Interest Clients:

8.7.1. When a suspicion of family maltreatment occurs in a family where a potential for conflict of interest with FAP staff and/or the FMCMT process may occur:

8.7.1.1. The FAO will coordinate with the Shaw AFB FAO and/or the Naval Weapon's Station director to determine assessments, FMCMT case staffing, and intervention provision.

8.7.1.2. The FAO will ensure that proper coordination, including sharing of all relevant information, occurs between these offices.

8.7.1.3. The FAO will ensure that appropriate notification procedures are maintained.

8.7.1.4. The FAC Chairperson will be briefed by the FAO in these situations regarding the plan for proceeding.

8.7.2. Conflict of interest clients may include FAP staff, Behavioral Science Flight staff, and members of the FMCMT.

8.8. Removal of family members involved in suspected family maltreatment:

8.8.1. The CAFB FAP does not have authority to remove children from their homes.

8.8.2. The respective County CPS staff, in coordination with their local law enforcement and judges, may remove children from their homes.

8.8.3. When a child is believed to be in imminent danger and the local CPS will not remove the child, other temporary options for decreasing risk of maltreatment may be considered, including having:

8.8.3.1. The non-offending parent take the child to a friend, extended family member or neighbor's home.

8.8.3.2. The alleged offender sponsor stay in the dorms, billeting or at a friend, co-worker or neighbor's home.

8.8.3.3. The non-offending parent take the child to stay with them in billeting, hotel or shelter, or at a friend, extended family member or neighbor's home (the FAP office has contact numbers for local shelters).

8.8.3.4. The medical official(s) keep the child through medical custody until further arrangements can be made.

8.8.3.5. The non-offending parent request an Order of Protection (the FAP office has contact numbers and instructions for family members to follow).

8.8.3.6. The non-offending parent request an ADT Duress System (the FAP office has the request form, which is filed through SFS, and maintains contact numbers and instructions for

family members to follow).

8.8.3.7. The non-offending parent request assistance through the community Victim Advocate Council (the FAP office has contact numbers and instructions for family members to follow).

8.8.3.8. The non-offending parent request aid through the SJA's VWAP (the Legal office has information and instructions for family members to follow).

8.8.4. The same options as above can be followed for spouses, including billeting, hotels, shelters, neighbors, friends, co-workers and extended family member's homes.

8.8.5. FAP staff and CC/CCF's will ensure that safety plans are in effect and that all involved understand the options and potential consequences of actions, as safety permits.

8.9. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

9. Information Release: FAP records are government property and information will only be released IAW Federal laws, and DoD and Air Force Directives. The FAO will review the release of FAP information policy with the SJA annually.

9.1. Procedures for the release of FAP records to subject(s) or family members.

9.1.1. All requests for FAP records will be forwarded to the FAO immediately.

9.1.2. The FAO will review the request and advise requestor on procedures IAW the Air Force Privacy Act Program and/or the Freedom of Information Act (FOIA) Program.

9.1.3. Once appropriate documentation, including a signed release form is received by the FAP:

9.1.3.1. The FAO will review it.

9.1.3.2. The FAPA will make two copies of the entire record, as requested.

9.1.3.3. The FAPA will place one of the copies in the left-hand side of the Request folder.

9.1.3.4. The FAPA will place second copy in the right-hand side of the folder behind the request.

9.1.3.5. The FAPA will place a post-it note on the right-hand pocket with the time to compile the package noted.

9.1.3.6. The FAPA will provide the package to the FAO within one day of receipt of approved request.

9.1.3.7. The FAO will review the copy from the left-hand side and highlight areas recommended for redaction.

9.1.3.8. The FAO will compile total hours and note on worksheet in package.

9.1.3.9. The FAO will ensure that the Request is completed and hand-carried to the SJA by the deadline.

9.1.3.10. The SJA will review the Request package before release to the requestor.

9.1.4. If the original FAP record is released, a copy must be made and filed in the FAP office.

9.2. Military or civilian agency release.

9.2.1. Information may be released to other departments or agencies that have a legitimate and proper need for access.

9.2.2. Written consent is not required for:

9.2.2.1. Release to the AFOSI.

9.2.2.2. Release to Federal or State Courts and other administrative bodies.

9.2.2.3. Release to other government department or agencies.

9.2.2.4. Release to medical research or scientific organizations.

9.2.2.5. Information on welfare of the individual or vital statistical data such as proof of birth and death.

9.2.2.6. Complying with court orders, subpoenas, or current law.

9.2.3. When OSI, the court or any other military or civilian agency, including when Command requests FAP information, the letter of request will be filed in the FAP, NPSP or FAST Services Record. The letter of request will include:

9.2.3.1. Appropriate signature.

9.2.3.2. Purpose of the request for information.

9.2.3.3. The requesting agency case number (when applicable).

9.2.4. The FAP staff will only release as much information as necessary to satisfy the purpose of the request.

9.2.5. In all cases, the receiver must be positively identified by the releases.

9.3. Release to the Public.

9.3.1. Under no circumstances shall personnel release medical information to the public.

9.3.2. All such requests from the news/media will be forwarded to the FAO, who will contact the appropriate Medical Group chain-of-command and Public Affairs, as necessary.

9.3.2.1. The Medical Group chain-of-command and Public Affairs will be notified when news/media contact the FAP regarding an alleged incident involving a military member.

9.3.2.2. The Public Affairs Commander or Deputy will also be notified during duty hours, and after duty hours via the Command Post, in all alleged family maltreatment incidents occurring off-base where civilian law enforcement and/or medical personnel respond.

9.3.3. The FAP client has the right to expect all confidential information (i.e., medical, personal, social, economic, etc.) to be held in strict confidence by all members of the health care team.

9.4. Requests for release of specific information.

9.4.1. FAP clients will complete and sign the Family Advocacy Program Release of Information form.

9.4.2. Information is releasable if both adults give written consent to release the information, and when a proper subpoena signed by a judge is presented from the court.

9.4.3. Normally, written consent by the patient or legal representative is required before release of the medical information. Legal representatives are as follows:

9.4.3.1. For dependent children, either parent signs.

9.4.3.2. For deceased persons, the next of kin signs and furnishes proof of death.

9.4.3.3. For physically/mentally incompetent persons, the guardian signs and furnishes a court order.

9.4.4. The FAP staff will only release as much information as necessary to satisfy the purpose of the request.

9.4.5. The FAO will review all written correspondence from FAP staff before its release.

9.4.6. A copy of the requested information/correspondence will be placed in the FAP record.

9.5. Release for case management purposes.

9.5.1. If treatment is obtained outside the FAP, the client will sign a release of information for the FAP staff and outside provider/agency, or provide Family Advocacy with case summaries from the outside provider/agency.

9.5.2. The FAP clinician working with the family will inform the client of what types of information will be requested and shared with the outside provider/agency.

9.5.3. The FAP staff will only release as much information as necessary to satisfy the purpose of the request.

9.6. Requests to read record.

9.6.1. The FAO will be informed of all such requests and will consult SJA before any review.

9.6.2. If approved, the FAP clinician working with the client should review the record with the client and be available to explain jargon and annotations, as necessary.

9.6.3. The FAP clinician working with the client will note in the FAP record when the client read the record.

9.6.4. In no situation will the client be allowed to leave the FAP office with the record.

9.6.5. Subsequent requests for copies of the record will follow guidance as outlined above.

9.6.6. Clients may review all the information in the record only when all adult family members have signed consent for release of the information to other adult family members.

9.6.7. Even when all adult family members have given written consent, access to children's information may still be masked if it puts them at risk.

9.7. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

10. Child Supervision Guidelines.

10.1. The following is guidance for CAFB parents when making decisions regarding the care and supervision of their children.

10.1.1. Reference [Attachment 2](#) for Age Guidelines.

10.1.2. The age of the child is not the only factor parents should consider when deciding if children should be left alone. Other factors include:

- 10.1.2.1. Level of maturity.
- 10.1.2.2. Emotional development.
- 10.1.2.3. Physical health.
- 10.1.2.4. Length of time left alone.
- 10.1.2.5. Time of day or night.
- 10.1.2.6. Other children present or to be supervised.
- 10.1.2.7. Location and environmental conditions.
- 10.1.2.8. Frequency of being left alone.
- 10.1.2.9. The accessibility of a parent or other responsible adult.

10.2. Inadequate supervision may occur in circumstances where:

10.2.1. The responsible caretakers are present, but are physically or mentally impaired to such an extent they are unable to provide proper supervision.

10.2.2. The child is left to provide supervision or care for himself, but is unable to do so.

10.3. The ultimate responsibility for the safety, care, well-being and behavior of children remains with the parents, whether or not they are present to supervise their children.

10.4. Any discrepancies or concerns with this plan will be elevated to the FAO who will raise them to the FAC Chairperson and others, as appropriate.

11. NPSP.

11.1. The NPSP has been developed to prevent all types of maltreatment through focusing on intensive services for those AF families expecting children and until the family's children reach 3 years of age, and are identified as high risk for maltreatment.

11.2. Participation in the NPSP is voluntary. Services may include home visits, classes, support groups, information and referral, and individual, marital and family counseling.

11.2.1. The needs of the family indicate which type(s) of services may be offered.

11.2.2. Services are offered repeatedly throughout the 0-3 years of age time-period.

11.3. The NPSP can receive referrals from the unit, medical group, other community agency, or self-identification.

11.3.1. The MPF will forward rosters of families with children up to three years of age and registered in the Defense Eligibility Enrollment System (DEERS) to the NPSP staff on a monthly basis and labels as requested.

11.3.2. The MTF will give out information regarding the NPSP to all newly identified expectant mothers.

11.3.3. The Managed Care Flight will forward identifying information to the FAN regarding mothers who have delivered their babies within the week they are delivered at a TRI-CARE-approved facility.

11.3.4. The Wing/CC will insert information regarding the NPSP in the letter sent to all newly delivered parents.

11.4. As a prevention program, notification to the CC/CCF is not made, unless there are significant safety or well-being concerns that necessitate such action (“need to know” scenarios), or when the family gives permission for such notification.

11.5. Similarly, as a prevention program, documentation in the OPMR is not made, unless there are significant safety or well-being concerns that necessitate such documentation or when the sponsor is on a special duty clearance.

11.6. The FAN will collaborate with the IDS agencies to facilitate NPSP classes/groups.

11.7. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

12. Fast Services.

12.1. FAST services are designed to provide psychosocial assessments and therapeutic interventions to families at risk for family maltreatment where there is no open maltreatment record and the family is not eligible for NPSP.

12.2. FAST services are not intended to replace LSSC services nor should chronic mental health problems be managed in this prevention program. In some cases, FAST services may augment a treatment program for a chronic mental health condition, with close collaboration between the primary mental health provider and the FAST services provider. FAST services clients will most often be characterized by maltreatment dynamics (spouse or child) or risk factors coupled with situational stress.

12.3. The FATM or the FAO may provide FAST services to active duty members and families on a space-available basis.

12.3.1. Services may include home visits, classes, support groups, information and referral, and individual, marital and family counseling.

12.3.2. The needs of the family indicate which type(s) of services may be offered.

12.4. Participation in FAST services is voluntary.

12.5. FAST services referrals can be made by the unit, medical group, other community agency, or self-identification.

12.6. As a prevention program, notification to the CC/CCF is not made, unless there are significant safety or well-being concerns that necessitate such action (“need to know” scenarios), or when the family gives permission for such notification.

12.7. Similarly, as a prevention program, documentation in the OPMR is not made, unless there are significant safety or well-being concerns that necessitate such documentation or when the sponsor is on a special duty clearance.

12.8. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

13. Special Needs Identification and Assignment Coordination Process.

13.1. Special Needs Identification.

13.1.1. All CAFB personnel will refer family members and their sponsors to the SNC when the family members meet the criteria listed on [Attachment 3](#).

13.1.2. The MPF will process SNI requests for activation and deactivation of Q-code status in a timely manner.

13.1.3. The MPF will forward Q-code rosters to the SNI staff on a monthly basis and labels on a quarterly basis.

13.1.4. Special Needs Screeners (SNS):

13.1.4.1. The MPF will:

13.1.4.1.1. Have all active duty members in-processing to CAFB complete the SNS if they have family members.

13.1.4.1.2. Forward the completed SNS to the FMRC Coordinator as they are completed and at least in the week they are received.

13.1.4.1.3. Forward lists to the FMRC Coordinator of information regarding sponsors in-processing to CAFB as they are completed and at least in the week they are received.

13.1.4.2. The FMRC Coordinator will:

13.1.4.2.1. Notify the SNC.

13.1.4.2.2. Contact the sponsor for an appointment.

13.1.4.2.3. Compile data obtained from the SNS.

13.1.5. Composite Health Care System (CHCS) pull:

13.1.5.1. The SNC will work with the Health Care Integration Chief at least annually to pull from the CHCS information regarding family members that may need to be assessed for SNI, including:

13.1.5.1.1. Those family members having common special needs diagnosis.

13.1.5.1.2. Those family members having consults to common specialty providers.

13.1.5.2. The SNC and FMRC Coordinator will attempt to contact these family members regarding potential SNI.

13.1.5.3. The sponsors will provide documentation for SNI, as appropriate and required.

13.1.6. The FMRC Coordinator and SNC will be available to provide briefings/trainings to any individual, unit, squadron, group, or agency, as requested. Agency directors and CC/CCFs are encouraged to the SNC to schedule this invaluable training.

13.2. Assignment Coordination Process:

13.2.1. FMRC:

13.2.1.1. Background:

13.2.1.1.1. The FMRC is a mandatory process for all family members traveling overseas

with their sponsors and for those sponsors with Q-code identification traveling to a state-side base.

13.2.1.1.1.1. Q-code identification occurs when a sponsor is identified as having a family member(s) with special education or medical conditions, including emotional needs. This assignment limitation code indicates a sponsor has a family member with a special need, which must be considered in the assignment process. It is initiated by the SNC and the code is put into the system by the local Military Personnel Flight (MPF) staff. The "Q-code" remains in effect as long as the special need exists, the family is eligible for care, and the sponsor is active duty. When two parents of a special needs child are active duty and one retires/separates the sponsor still on AD must receive the Q-code designation.

13.2.1.1.1.1.1. A special needs medical condition for the FMRC is defined as any condition that CANNOT be met by a family practice physician working with no additional specialty consultation. Even if the patient is not currently receiving treatment, but has a condition that may require care, they are considered to have a special need.

13.2.1.1.1.1.2. All family members with special education needs will also be screened for travel.

13.2.1.1.1.1.2.1. This is a service provided to AF families to help them become aware of the potential education limitations at a new location.

13.2.1.1.1.1.2.2. Schools determine special education needs (i.e., school-age child with an Individual Education Plan (IEP), or Early Intervention Services (EIS) for a birth-to-three age child with an Individual Family Service Plan (IFSP), including children being evaluated for special education or early intervention services).

13.2.1.1.1.2. All family members of active duty (AD) Air Force (AF) sponsors with an overseas assignment requesting travel, regardless of special needs, will be screened within six months of Permanent Change of Station (PCS), for special medical and educational needs.

13.2.1.1.1.3. For stateside travel, only those family members with special medical needs must be screened.

13.2.1.1.1.4. For families where the sponsor takes a remote assignment with a follow-on assignment, an initial FMRC will be conducted for the follow-on location before orders for the remote assignment are published.

13.2.1.1.1.4.1. The sponsor will be told to request another FMRC within six months of their travel.

13.2.1.1.1.4.2. All sponsors and family members will be briefed about this requirement and the need to notify the Special Needs Coordinator (SNC) of any new special medical and/or educational needs that arise between the times of screening and travel.

13.2.1.1.1.5. Active duty from other Military Services will be screened using their

Service paperwork.

13.2.1.1.2. This process must be completed in order for family members to be placed on PCS orders.

13.2.1.2. Responsibilities:

13.2.1.2.1. The MPF will:

13.2.1.2.1.1. Provide all sponsors meeting the above criteria a FMRC packet containing:

13.2.1.2.1.1.1. CAFB FMRC Checklist.

13.2.1.2.1.1.2. AF Form 1466, **Request for Family Member's Medical and Education Clearance for Travel**, 28 February 2002.

13.2.1.2.1.1.3. CAFB Dental Screener.

13.2.1.2.1.1.4. AF Form 1466 DO, **Dental Health Summary**, 28 February 2002.

13.2.1.2.1.1.5. DD Form 2792, **Exceptional Family Member Medical and Educational Summary**, 1 February 2002, Addendum B, Special Education/Early Intervention Summary.

13.2.1.2.1.2. Brief these sponsors on out-processing requirements including the FMRC process.

13.2.1.2.1.3. Once a determination is made, counsel/assist sponsors in the PCS process, including making PCS orders.

13.2.1.2.1.4. Consult the SNC with any questions/concerns as they arise.

13.2.1.2.2. The sponsor will:

13.2.1.2.2.1. Follow guidance noted in the CAFB FMRC Checklist.

13.2.1.2.2.1.1. There are two portions to the dental portion of the FMRC:

13.2.1.2.2.1.1.1. All family members requesting PCS travel, age 2 and older, must have a dental exam within the last 12 months.

13.2.1.2.2.1.1.2. All unresolved dental care needs/problems (i.e. untreated dental cavities, orthodontics, toothaches, periodontal conditions, TMJ/TMD, etc.) for these family members must be documented.

13.2.1.2.2.1.2. Sponsor's have two options for completion of the dental portion of the FMRC:

13.2.1.2.2.1.2.1. Sponsor's who have family members who have had dental care off-base, may take the Dental Screener and AF Form 1466 DO to this dentist for completion.

13.2.1.2.2.1.2.2. Sponsor's who have family members who have not had dental care off-base and are not enrolled in the Concordia Dental Plan, may take the Dental Screener and AF Form 1466 DO to the Deily Dental Clinic for completion.

- 13.2.1.2.2.2. Consult the FMRC Coordinator or SNC with any questions/concerns as they arise.
 - 13.2.1.2.2.3. Take completed documentation from the FMRC packet to the FMRC Coordinator for review.
 - 13.2.1.2.2.4. Provide additional information as requested by the FMRC Coordinator, including
 - 13.2.1.2.2.5. Ensure all family members are registered in DEERS and TRICARE before FMRC appointment.
 - 13.2.1.2.2.6. Arrive at the FMRC appointment 15 minutes early.
 - 13.2.1.2.2.7. Provide additional information as requested by the SNC or Medical Reviewer.
 - 13.2.1.2.2.8. Once a determination is made, pick-up the AF Form 1466 from the FMRC Coordinator.
 - 13.2.1.2.2.9. Notify the SNC or FMRC Coordinator of any new special medical and/or educational needs that arise between the time of screening and travel.
- 13.2.1.2.3. The FMRC Coordinator will:
- 13.2.1.2.3.1. Instruct sponsors on the details of the FMRC process during the MPF Mandatory Out-processing briefing.
 - 13.2.1.2.3.2. Review sponsors FMRC packet documentation.
 - 13.2.1.2.3.3. Request sponsors complete additional documentation as needed.
 - 13.2.1.2.3.4. Book the sponsor and all geographically available family members for the FMRC appointment in Composite Health Care System (CHCS).
 - 13.2.1.2.3.5. Elevate complications/concerns to the SNC as needed.
- 13.2.1.2.4. The Medical Reviewer will:
- 13.2.1.2.4.1. Follow FMRC procedures as outlined in Medical Group Instruction (MGI) 40-09, *Special Needs Identification and Assignment Coordination Process Procedures*.
 - 13.2.1.2.4.2. Review all traveling family members medical records for special medical and educational needs/services.
 - 13.2.1.2.4.3. Consult with the SNC and review any additional information before the interview with the family.
 - 13.2.1.2.4.4. Interview all families for additional information/clarification (confidentiality of the sponsor and all family members will be maintained during the interview, allowing for individual interviews when requested).
 - 13.2.1.2.4.5. Complete Section V of the AF Form 1466.
- 13.2.1.2.5. The Special Needs Coordinator (SNC) will:
- 13.2.1.2.5.1. Ensure all involved personnel are aware and understand procedures for

the identification of sponsors with family members with special needs.

13.2.1.2.5.2. Ensure all involved personnel are aware and understand procedures for the coordination of the FMRC.

13.2.1.2.5.3. Ensure all scheduled FMRC families have appropriate documentation completed.

13.2.1.2.5.4. Ensure all geographically available family members attend FMRC appointment, as appropriate.

13.2.1.2.5.5. Conduct the joint interview with the family during the FMRC appointment.

13.2.1.2.5.6. Complete Section VI of the AF Form 1466.

13.2.1.2.5.7. Provide the sponsor, or other representative, with the completed AF Form 1466 if travel is recommended.

13.2.1.2.5.8. Provide the sponsor with information on the procedures for an FDI if travel is not recommended.

13.2.1.2.5.9. Provide the sponsor with information on SNI if a family member(s) needs meet criteria.

13.2.1.2.5.10. Ensure FMRCs are completed within established timelines.

13.2.1.2.5.11. Elevate complications/concerns as needed.

13.2.1.2.6. The Dental Commander will:

13.2.1.2.6.1. Ensure Deily Dental Clinic staff follow necessary procedures described in MGI 40-09, *Special Needs Identification and Assignment Coordination Process Procedures*.

13.2.1.2.6.2. Review any available dental documentation available.

13.2.1.2.6.3. Coordinate concerns, changes, and questions through the SNC, as needed.

13.2.1.3. Overseas Assignment Coordination of DoD Civilian Employees.

13.2.1.3.1. The SNC will brief the local Civilian Personnel Office (CPO) on the FMRC process available to all GS employees traveling overseas. The FMRC is a voluntary process for DoD civilians.

13.2.1.3.2. The SNC screens all DoD civilian employees who request identification of availability of resources at an overseas location. There is no requirement that CPO receive completed FDIs.

13.2.1.3.3. The SNC will follow the FMRC process above except patient information release forms must be obtained from all adults before information can be shared with the gaining MTF.

13.2.1.3.3.1. Once the FDI is completed by the gaining MTF the information is given to the employee and will not be forwarded to the CPO without written authorization from the DoD civilian employee.

13.2.1.3.3.2. The SNC will not maintain documentation on civilian employee clearances.

13.2.1.3.3.3. No information will be shared with anyone without a Release of Information from the employee. The civilian employee must initiate this process.

13.2.1.3.3.4. The gaining base does not have the authority to approve or disapprove civilian family member travel, only provide information on service availability.

13.2.1.3.3.5. Contract employees obtain information on resources through the contract employer.

13.2.2. FDI: An inquiry to the sponsor's gaining base, which details specialized medical and/or educational needs of family members and requests a determination of whether travel is recommended or not for the family members listed.

13.2.2.1. Out-going.

13.2.2.1.1. The FMRC Coordinator will:

13.2.2.1.1.1. Coordinate the FDI process.

13.2.2.1.1.2. Track the FDI and ensure response is received within timeline.

13.2.2.1.1.3. Notify the SNC immediately when there are delays/concerns regarding this process.

13.2.2.1.1.4. Upon receipt of the FDI response:

13.2.2.1.1.4.1. Make a copy for the SNI record, as appropriate.

13.2.2.1.1.4.2. Contact the sponsor to pick-up their AF Form 1466 to take to the MPF and provide the sponsor with information received from the gaining base regarding care.

13.2.2.1.1.4.3. Notify the SNC of the results.

13.2.2.1.2. The Special Needs Coordinator (SNC) will:

13.2.2.1.2.1. Ensure necessary procedures are followed within timelines.

13.2.2.1.2.2. Elevate concerns/delays as needed.

13.2.2.1.2.3. Ensure the sponsor, or designated representative, is notified immediately of travel recommendation.

13.2.2.1.3. The sponsor will:

13.2.2.1.3.1. Pick-up their AF Form 1466 from the SNI office.

13.2.2.1.3.2. Take the AF Form 1466 to the MPF for processing of their orders.

13.2.2.1.3.3. Contact the gaining base regarding any additional details regarding their family member's care.

13.2.2.1.3.4. If Q-code identified:

13.2.2.1.3.4.1. Notify the SNC or FMRC Coordinator before their PCS departure.

13.2.2.1.3.4.2. Notify the SNC or FMRC Coordinator at their gaining base once

they arrive.

13.2.2.2. In-coming.

13.2.2.2.1. The FMRC Coordinator will:

13.2.2.2.1.1. Forward (fax or call) any educational needs documentation to the local civilian special education point-of-contact (depending on county—if no county specified, forward to Charleston County).

13.2.2.2.1.2. Complete the FDI coversheet.

13.2.2.2.1.3. Provide the FDI in a two-part blue folder to the SNC for review.

13.2.2.2.1.4. Hand-carry the FDI blue folder to the TRICARE office (Managed Care Flight) reviewer.

13.2.2.2.1.5. Ensure the FDI blue folder is taken to the Chief of Medical Staff (SGH).

13.2.2.2.1.6. Elevate any delays/concerns to the SNC immediately.

13.2.2.2.1.7. Ensure completion of Section VII of the AF Form 1466.

13.2.2.2.1.8. Ensure the FDI response is faxed back to the FMRC coordinator within 14 calendar days of its receipt.

13.2.2.2.1.9. Respond to FDIs from Air Force Personnel Center (AFPC) as quickly as possible (should manage these requests within several days).

13.2.2.2.2. The Special Needs Coordinator (SNC) will:

13.2.2.2.2.1. Ensure the FDI keeps flowing within the medical group offices.

13.2.2.2.2.2. Ensure the SGH signs Section VII of the AF Form 1466 noting the FDI disposition.

13.2.2.2.2.3. Ensure the FDI response is faxed back to the FMRC coordinator within 14 calendar days of its receipt.

13.2.2.2.2.4. Ensure that FDIs from AFPC are coordinated and responded to as quickly as possible.

13.2.2.2.2.5. Elevate any delays/concerns to the SNC immediately.

13.2.2.2.3. The Managed Care Flight will:

13.2.2.2.3.1. Review the FDI.

13.2.2.2.3.2. Note recommendation on the FDI Coversheet.

13.2.2.2.3.3. Forward FDI blue folder to the FMRC Coordinator or directly to the SGH within two days of receipt (FDIs from AFPC will be forwarded within the same duty day received, if at all possible).

13.2.2.2.3.4. Any delays will be coordinated through the FMRC Coordinator.

13.2.2.2.4. The SGH will:

13.2.2.2.4.1. Review the FDI.

13.2.2.2.4.2. Note recommendation on the FDI Coversheet.

13.2.2.2.4.3. Forward FDI blue folder to the FMRC Coordinator within two days of receipt (FDIs from AFPC will be forwarded within the same duty day received, if at all possible).

13.2.2.2.4.4. Any delays will be coordinated through the FMRC Coordinator.

13.2.3. Special Needs Reassignment:

13.2.3.1. The SNC will:

13.2.3.1.1. Meet with the sponsor regarding reassignment options.

13.2.3.1.2. Provide the sponsor with a copy of Attachment 7 from AFI 36-2110, *Assignments*, 1 February 2000 as needed.

13.2.3.1.3. Refer the sponsor to the MPF for additional details and to notify them of the sponsor's plans.

13.2.3.1.4. If the sponsor decides to proceed with a Reassignment request:

13.2.3.1.4.1. Review the sponsor's application.

13.2.3.1.4.2. Provide a letter for inclusion in the Reassignment package.

13.2.3.1.4.3. Ensure all necessary documentation is included in the package.

13.2.3.1.4.4. Assist the sponsor in routing and obtaining necessary support/signatures.

13.2.3.1.4.5. Ensure the package is routed through TRICARE, the SGH and the MTF/CC.

13.2.3.1.4.6. Meet with the MTF reviewers as requested/needed.

13.2.3.1.4.7. Contact the sponsor for pick-up once the package is complete.

13.2.3.1.4.8. Ensure the sponsor understands to take the package to the MPF.

13.2.3.1.4.9. Request the sponsor contact the SNC when they are informed of the determination.

13.2.3.1.5. Ensure the Sponsor is notified once the determination is made by AFPC.

13.2.3.2. The Sponsor will:

13.2.3.2.1. Contact the SNC regarding reassignment options.

13.2.3.2.2. Review and follow procedures outlined in Attachment 7.

13.2.3.2.3. Notify the MPF of plan to proceed with Reassignment.

13.2.3.2.4. Draft application and obtain necessary supporting documentation.

13.2.3.2.5. Meet with the SNC to review reassignment application package.

13.2.3.2.6. Route and obtain necessary signatures.

13.2.3.2.7. Pick-up the signed package from the SNI office and take it to the MPF within 30 days of notification.

- 13.2.3.2.8. Keep the SNC apprised of status.
- 13.2.3.2.9. Consult the SNC with any questions/concerns as they arise.
- 13.2.3.3. The Managed Care Flight will:
 - 13.2.3.3.1. Review the sponsor's application package.
 - 13.2.3.3.2. Note recommendation on the routing slip.
 - 13.2.3.3.3. Forward application package to the SGH within one day of receipt, if possible.
 - 13.2.3.3.4. Any delays will be coordinated through the SNC.
- 13.2.3.4. The SGH will:
 - 13.2.3.4.1. Review the sponsor's application package.
 - 13.2.3.4.2. Note recommendation on the routing slip.
 - 13.2.3.4.3. Forward sponsor's application package to the MTF/CC within one day of receipt, if possible.
 - 13.2.3.4.4. Any delays will be coordinated through the SNC.
- 13.2.3.5. The MTF/CC will:
 - 13.2.3.5.1. Review the sponsor's application package.
 - 13.2.3.5.2. Note whether concur or non-concur and sign on the last page of the sponsor's application.
 - 13.2.3.5.3. Forward sponsor's application package to the SNC within one day of receipt, if possible.
 - 13.2.3.5.4. Any delays will be coordinated through the SNC.
- 13.2.3.6. The MPF will:
 - 13.2.3.6.1. Provide sponsors with information on the Reassignment process and confirm eligibility criteria.
 - 13.2.3.6.2. Brief sponsors on Reassignment requirements and ensure application package in proper format.
 - 13.2.3.6.3. Once a determination is made, counsel and assist sponsors in the reassignment process, including generating PCS orders.
 - 13.2.3.6.4. Consult the SNC with any questions/concerns as they arise.
- 13.2.3.7. The Air Force Personnel Center (AFPC) will:
 - 13.2.3.7.1. Review the sponsor's application package.
 - 13.2.3.7.2. Make a determination.
 - 13.2.3.7.3. Respond with a travel determination.
- 13.2.3.8. Reference Attachment 7 from AFI 36-2110 for additional details regarding procedures.

13.2.4. Special Needs Deferment:

13.2.4.1. Follow the procedures as listed above for Special Needs Reassignment.

13.2.4.2. Reference Attachment 7 from AFI 36-2110 for additional details regarding procedures.

13.2.5. Humanitarian Reassignment:

13.2.5.1. The SNC will provide services as detailed in paragraph 4.3.1. , as requested, except:

13.2.5.1.1. Encourage the sponsor to consider including a letter from a Chaplain and/or CCF.

13.2.5.1.2. Ensure the package is routed through the SGH and the MTF/CC.

13.2.5.1.2.1. IAW AFI 36-2110, the MTF/CC is responsible for signing the sponsor's application after having reviewed the medical documentation included as supporting documentation.

13.2.5.1.2.2. The MTF/CC does not make any determinations regarding service availability, but rather confirms that the documentation is sufficient.

13.2.5.2. The Sponsor will:

13.2.5.2.1. Contact the SNC regarding reassignment options.

13.2.5.2.2. Review and follow procedures outlined in Attachment 7.

13.2.5.2.3. Notify the MPF of plan to proceed with Reassignment.

13.2.5.2.4. Draft application and obtain necessary supporting documentation.

13.2.5.2.5. Route and obtain necessary signatures.

13.2.5.2.6. Pick-up the signed package from the MTF/CC's office and take it to the MPF within 30 days of notification.

13.2.5.2.7. Consult the SNC with any questions/concerns.

13.2.5.3. The SGH will:

13.2.5.3.1. Review the sponsor's application package.

13.2.5.3.2. Note recommendation on the routing slip.

13.2.5.3.3. Forward sponsor's application package to the MTF/CC within one day of receipt, if possible.

13.2.5.3.4. Any delays will be coordinated through the MTF/CC's Executive Officer.

13.2.5.4. The MTF/CC will:

13.2.5.4.1. Review the sponsor's application package.

13.2.5.4.2. Note whether concur or non-concur and sign on the last page of the sponsor's application.

13.2.5.4.3. Forward sponsor's signed package to the MTF/CC's Executive Officer within one day of receipt, if possible.

- 13.2.5.5. The MTF/CC's Executive Officer will contact the sponsor for pick-up.
- 13.2.5.6. The MPF will provide services as noted above in Special Needs Reassignment section.
- 13.2.5.7. The AFPC will provide services as noted above in Special Needs Reassignment section.
- 13.2.6. Sponsors not stationed at CAFB.
 - 13.2.6.1. The same procedures, as outlined above, will be followed for sponsors located at Geographically Separated Units, except with FMRCs:
 - 13.2.6.1.1. Medical Records will not be required.
 - 13.2.6.1.2. DoD Medical Summary and appropriate Addendums will be required.
 - 13.2.6.1.3. Required documentation may be emailed, mailed or faxed to the SNI office.
 - 13.2.6.1.4. The FMRC appointment may be conducted telephonically or the family may come to the appointment in person. Each family's situation will be considered by the SNC on a case-by-case basis.
 - 13.2.6.1.5. The MPF-assigned to the sponsor will coordinate the FMRC.
 - 13.2.6.2. The same procedures, as outlined above, will be followed for sponsors TDY or on leave to CAFB, except with Humanitarian, Special Needs Reassignment and Deferment Applications:
 - 13.2.6.2.1. The CC's recommendation requirement is waived if the situation precludes the sponsor from obtaining it.
 - 13.2.6.2.1.1. However, the sponsor must still notify and obtain approval by the CC. Emailed, mailed or faxed correspondence stating such may be used.
 - 13.2.6.2.1.2. The application must also state the reason for omitting the CC's recommendation.
 - 13.2.6.2.2. The application package may be routed through the CAFB MTF or the sponsor's MTF. Each family's situation will be considered by the SNC on a case-by-case basis.
- 13.2.7. Any discrepancies or concerns with this plan will be elevated by the FAO to the FAC Chairperson and others, as appropriate.

BROOKS L. BASH, Colonel, USAF
Commander

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

AFI 36-2110, *Assignments*

AFI 36-2603, *Air Force Board for Corrections of Military Records*

AFI 40-301, *Family Advocacy*

AFI 90-501, *Community Action Information Board and Integrated Delivery System*

Abbreviations and Acronyms

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

ADC—Area Defense Council

AD HOC—Called when needed

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFMAN—Air Force Manual

AFMOA/SGZF—Air Force Medical Operations Agency, Office of the Surgeon General, Family Advocacy Program

AFOSI—Air Force Office of Special Investigations

AFPC—Air Force Personnel Center

AFPD—Air Force Policy Directive

AFSC—Air Force Specialty Code

AF/SG—Air Force Surgeon General

AW/CC—Air Wing Commander

CAIB—Community Action Information Board

CAFB—Charleston Air Force Base

CDC—Child Development Center

CC—Commander

CCAP—Community Capacity Action Plan

CONUS—Continental United States

CPS—Child Protective Services

CSMRT—Child Sexual Maltreatment Response Team

DCII—Defense Clearance and Investigations Index

DEERS—Defense Eligibility Enrollment System
DoD—Department of Defense
DoDD—Department of Defense Directive
DoDEA—Department of Defense Education Activity
DoDI—Department of Defense Instruction
EIS—Early Intervention Services
FAC—Family Advocacy Committee
FACAT—Family Advocacy Command Assistance Team
FAN—Family Advocacy Nurse
FAO—Family Advocacy Officer
FAOM—Family Advocacy Outreach Manager
FAP—Family Advocacy Program
FAPA—Family Advocacy Program Assistant
FAST—Family Advocacy Staff Training
FATM—Family Advocacy Treatment Manager
FCCH—Family Child Care Home
FDI—Facility Determination Inquiry
FM—Family Member
FMCMT—Family Maltreatment Case Management Team
FMRC—Family Member Relocation Clearance
FSC—Family Support Center
HAWC—Health and Wellness Center
HRVRT—High Risk for Violence Response Team
HSI—Health Services Inspection
IAW—In Accordance With
IDS—Integrated Delivery System
IEP—Individualized Educational Program
I&R—Information and Referral
ISDR—Incident Status Determination Review
ISSA—Inter-Service Support Agreement
JCAHO—Joint Commission on Accreditation of Healthcare Organizations
LSSC—Life Skills Support Center

MAJCOM—Major Command

MCFAPM—Major Command Family Advocacy Program Manager

MDG/SGH—Medical Group Chief of Clinical Medicine

MOU—Memoranda of Understanding

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

NPSP—New Parent Support Program

OCONUS—Outside Continental United States

PCS—Permanent Change of Station

PPWD—Programs for Persons With Disabilities

PL—Public Law

Q-CODE—Assignment Limitation Code-Q

SFS—Security Forces Squadron

SFS/SFOSI—Security Forces Squadron Office of Investigations

SG—Surgeon General

SJA—Staff Judge Advocate

SNC—Special Needs Coordinator

SNI—Special Needs Identification

TDY—Temporary Duty

VWAP—Victim Witness Assistance Program

Terms

ACTIVITIES—Services, initiatives and actions that facilitate enhancement of quality of life, foster awareness, commitment to change; impact knowledge, and attitudes and, behavior resulting in the achievement of Program Results. Activities target leadership, formal agencies and the informal community.

ACT OF FORCE—An act against another person including, but not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, use of restraints, use of a weapon (gun, knife or other object), or use one's body, size, or strength.

AF FAMILY ADVOCACY PROGRAM STANDARDS—Specific rules and protocols for practice that implement the DoD Family Advocacy Program Instructions and Standards and the Air Force Policy Directive 40-3 and Instruction 40-301. FAP Standards set minimum requirements for program implementation.

AFIA—Air Force Inspection Agency, which evaluates the adequacy and effectiveness of FAP services.

AFMOA—Air Force Medical Operations Agency, Office of the Surgeon General.

AFOSI—Air Force Office of Special Investigation.

AFPC—Air Force Personnel Center.

AF/SG—Air Force Surgeon General. The highest-ranking medical officer in the Air Force.

AIR FORCE FAP MANAGER—An individual designated by the secretary of the AF to manage, monitor, and coordinate the FAP at the headquarters level. Also, known as Chief, Family Advocacy Branch.

AIR FORCE COMMUNITY ASSESSMENT—This term usually refers to the assessment carried out in conjunction with the Integrated Delivery System (IDS) to assess strengths and needs in all support areas base wide.

AIR FORCE INSTRUCTION (AFI)—formerly known as AFR, AF Regulation.

ALLEGATION—A report claiming that maltreatment may have occurred.

ALLEGED OFFENDER—Any person, who causes the maltreatment of a child while in a caretaker role, or the maltreatment of his/her spouse, or whose act, or failure to act, substantially impaired the health or well being of the victim. Exception exists in cases of child sexual maltreatment when the alleged offender may not be in a caretaker role but was in a position of power over the victim.

ANONYMOUS REPORTER—The individual reporting suspected maltreatment chooses to be unidentified. (Note: Therefore, NO IDENTIFYING information on the reporter shall be annotated in the FAP record on an intake form or in the log.)

ASSESSMENT—Application of diagnostic methods to evaluate, analyze critically, and judge definitively the nature, significance, status or merit, importance or size of a need, problem, or issue. A bio-psychosocial clinical assessment is accomplished through interviews, questionnaires, and reliable collateral information.

AT RISK POPULATION—Individuals or families that exhibit characteristics or behaviors known to be associated with family maltreatment.

BEHAVIORAL HEALTH SURVEY—A formal research tool developed by the Johnson Institute to assist the Integrated Delivery System in designing more effective prevention and wellness programs tailored to the needs of specific squadrons.

CAIB: COMMUNITY ACTION INFORMATION BOARD—An executive committee representing base leadership and organizational leadership who direct the cross-functional collaboration of base support agencies. The CAIB approves policy, directs actions, makes recommendations and gives approval on issues that are aimed at supporting Air force active duty, their families and community.

CAREGIVER—An individual or group of individuals in a position of responsibility for the temporary or permanent care/supervision of a minor or a person of any age who is incapable of self-support because of a developmental or physical challenge (special needs adult). Such care and/or supervision may be provided in the child's home, in a military sanctioned caregiver's home, at a military sponsored or military sanctioned out-of-home care facility or a residential facility, or in an activity conducted at various locations. A caregiver may be:

- a. *A family member*: An individual who is related by blood, law, or marriage to the child or special needs adult for whom he or she is providing care, or...

- b. *Extra-familial caregiver*: The classification of an alleged offender as unrelated to the victim by blood, law, or marriage, (i.e., as outside of the victim's family) and who is an employee (including janitors, bus drivers, etc.), independent contractor, or volunteer in a military-sanctioned or military-sponsored program that provides care for and supervision of a child by agreement with the child's parent guardian, or foster parent. Such care and supervision maybe provided in the child's home, in a military-sanctioned caregiver's home, at a military-sponsored or military-sanctioned out-of-home care facility or residential facility, or in an activity conducted at various locations.
- c. *Extrafamilial Caregiver/Power Role (DoD Non-Sanctioned)*: This category is for extra-familial caregivers where there are allegations of child sexual abuse, and the caregiver was not in a DoD sanctioned role or activity. Also included are extra-familial offenders in a position of power over the alleged victim, and the offender was not in a DoD-sanctioned caregiver role or activity. Caregivers may be active duty members or their family members; retirees, or their family members; civilians, or juvenile in a position of power.

CASE—One or more alleged or substantiated incidents of child or spouse maltreatment pertaining to the same victim. A maltreatment allegation, with reasonable suspicion that maltreatment occurred, concerning an individual that meets the eligibility for FAP involvement.

CASE CLOSURE—

- a. *Case Closed-Resolved*: The case is administratively closed when no subsequent incident of maltreatment has recently occurred and the FMCMT determines that the intervention plan is complete and the risk of further maltreatment is minimal; when family members are separated and not in need of FAP services and the threat of maltreatment is minimal, or when death occurs.
- b. *Case Closed-Unresolved*: The case is closed when no subsequent incident has recently occurred, despite an incomplete intervention plan and or lack of client cooperation. Risk is considered higher than minimal, but FAP services are refused by the family.
- c. *Case Closed-Separated From Service*: The case is closed when sponsor is released from active military service.

CENTRAL REGISTRY—A central management information system maintained by each branch of Service for identifying and recording information on incidents of child and spouse maltreatment. The Air Force Family Advocacy Central Registry is located at AFMOA/SGZF, Brooks AFB, TX.

CHAMPUS/TRICARE (OR EQUIVALENT)—The third party medical insurance contractor covering services for military families currently utilized in a region.

CHILD—An unmarried person under the age of 18 who is eligible for care through a DoD medical treatment program and for whom a parent, guardian, foster parent, caregiver, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term "child" means a biological child, adopted child, stepchild, foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for who care in a military medical treatment program is authorized.

CHILD EMOTIONAL MALTREATMENT—Acts, or a pattern of acts, omissions or a pattern of omissions or passive-aggressive inattention to a child's emotional needs resulting in an adverse effect upon the child's psychological well-being. Maltreatment includes intentional berating, disparaging or other verbally abusive behavior toward the child; and violent acts that may not cause observable injury. An emotionally maltreated child manifests low self-esteem, chronic fear or anxiety, conduct disorders,

affective disorders, or other cognitive or mental impairment.

CHILD NEGLECT—A type of child abuse/maltreatment whereby a child is deprived of needed age-appropriate care by act or omission of the child's parent, guardian, caregiver, employee of a residential facility, or staff person providing out-of-home care under circumstances indicating that the child's welfare is harmed or threatened. Child neglect includes “Abandonment,” “Deprivation of Necessities,” “Educational Neglect,” “Lack of Supervision,” “Medical Neglect” and/or “Non-organic Failure to Thrive.”

- a. Abandonment: A type of child neglect in which the caregiver is absent and does not intend to return or is away from home for an extended period without having arranged for an appropriate surrogate caregiver.
- b. Deprivation of Necessities: A type of neglect that includes the failure to provide appropriate nourishment, shelter and clothing.
- c. Educational Neglect: A type of child neglect that includes knowingly allowing the child to have extended or frequent absences from school, neglecting to enroll a child in school or preventing the child from attending school for other than justified reasons.
- d. Lack of Supervision: A type of child neglect characterized by the absence or inattention of the parent, guardian, foster parent or other caregiver that results in injury to the child, in the child being unable to care for him/herself, or an injury or serious threat of injury to another person because the child's behavior was not properly monitored.
- e. Medical Neglect: A type of child neglect in which a parent or guardian refuses or fails to provide appropriate, medically necessary health care, (medical, mental health, dental) for the child although the parent is financially able to do so or was offered other means to do so.
- f. Non-Organic Failure to Thrive (FTT): A type of child neglect which manifests itself in an infant's or young child's failure to grow and develop when no organic basis for this deviation is found. Usually such children register below the third percentile in height and weight.

CHILD PHYSICAL ABUSE/ MALTREATMENT—Acts such as grabbing, pushing, holding, slapping, choking, punching, kicking, sitting or standing upon, lifting and throwing, burning, immersing in hot liquids or pouring hot liquids upon, hitting with an object (such as a belt or electrical cord), and assaulting with a knife, firearm or other weapon that caused or may cause bodily injuries. Such injuries include brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts. In infants and toddlers, abusive acts include shaking or twisting, which may cause brain damage, subdural hemorrhage, and hematoma. An injury does not have to be visible for physical maltreatment to be present.

CHILD SEXUAL MALTREATMENT—Any incidents of sexual activity with a child for the purpose of sexual gratification of the alleged offender or some other individual.

- a. Exploitation: A type of sexual maltreatment in which the victim is made to participate in the sexual gratification of another person without direct physical contact between them. Exploitation includes forcing or encouraging a child to do any of the following: to expose the child's genitals or (if female) breasts, look at another individual's exposed genitals or (if female) breasts, to observe another's masturbatory activities, to view pornographic photographs or read pornographic literature, to hear sexually explicit speech, or participate in sexual activity with another

person, such as in pornography or prostitution, in which the alleged offender does not have direct physical contact with the child.

- b. *Molestation*: Fondling or stroking of a child's breasts or genitals, oral sex, or attempted penetration of the child's vagina or rectum.
- c. *Rape/Intercourse*: Sexual intercourse between an alleged offender and a child that involves the penetration of the vagina or rectum, however slight, by means of physical force. The penetration may result from emotionally manipulating, the child or taking advantage of a child's naiveté rather than physical force.
- d. *Other Sexual Maltreatment*: All other types of child sexual abuse or maltreatment not included in the definitions of "Exploitation," "Molestation," or "Rape/Intercourse."
- e. *Child Sexual Maltreatment In DoD-Sanctioned Activities (formerly termed "Out-of-Home")*: Any child sexual maltreatment occurring during DoD-sanctioned activity in any location where the military service has sanctioned or authorized care of children by individuals other than their legal guardians. Examples include: CDCs, DoDEA schools, buses, recreation facilities, Licensed Home Day Care Facilities, DoD sponsored Boy/Girl Scout functions, Base Chapel, or locations where Red Cross trained baby-sitting occurs.

COLLABORATION—The procedure in which two or more professional's work together to serve a given client (individual, family, group, community, or population). The Air Force community can include all associated or identified with the Air Force, while a base community is a segment of the Air Force community aligned with a specific location at a particular time. The unit community is a segment of the base community aligned with a specific unit and mission at a particular time. Communities often share a common history, memory, culture and norms. Dimensions of Community include its infrastructure, socio-demographic make-up, institutions, and social capacity.

COLLATERAL CONTACTS—Any secondary contacts made in support of assessment and treatment of individual clients, i.e. medical providers, other mental health professionals, extended family members, etc.

COLLECTIVE COMPETENCE—The cumulative knowledge, awareness and skill of community members that facilitate ability to work together to accomplish collaborative community actions.

COMMUNITY—Can be both geographical and functional. Community is the social address of individuals and families: geographical, referring to where people live and work, functional, referring to where people find social support and have connections, personal interest and investment. In context community may refer to both on and off base people and locale.

- a. *Local Community*: Refers to the surrounding civilian community.
- b. *Air Force Community*: Refers to Air Force members and their families assigned to an installation; in context, may refer to the worldwide Air Force.

COMMUNITY-BASED PROGRAMS—Programs that target change through a macro system and community perspective. The conceptual framework is to maximize and impact knowledge, attitude, and behavior through methods derived from both clinical and grassroots experience. Community-based programs focus on building protective factors and addressing risk factors that affect the masses. The primary community programs and methods facilitate empowerment of the community through didactic education, psycho-educational processes, enhancement of social competence and support, and

community collaboration and action. Rather than a focus on one individual's or family's problem, community-based programs seek to facilitate global change and solutions beneficial to the largest population that will last over time.

COMMUNITY CAPACITY—Community capacity is achieved when the community has the ability to meet members' needs and goals, jointly solve problems, reinforce pro social norms, provide opportunities for meaningful participation, provide and express support, respond to external threats, maintain stability and order and create a psychological sense of belonging. In essence, community capacity is shared responsibility and collective competence.

COMMUNITY COHESION—Involves individual identification with a sense of psychological connection to others in the community

COMMUNITY ORGANIZATION: —An intervention process to help individuals, groups, and collectives of people with common interests or from the same geographic areas to deal with social problems and to enhance social well being through planned collective action. Methods include identifying problem areas, analyzing causes, formulating plans, developing strategies, and mobilizing necessary resources, identifying and recruiting community leaders, and encouraging interrelationships among them to facilitate their efforts.

COMMUNITY RESILIENCE—The ability of a community to achieve better-than-expected outcomes in the face of adversity. Community cohesion and social capacity enhance resilience. Community cohesion involves individual identification with a sense of psychological connection to others in the community. Social capacity is a community's ability to bring members together and create a psychological sense of connection in order to develop resources and opportunities for meeting the individual and collective needs and goals of members.

COMMUNITY RESULTS—Distal outcomes that reflect ultimate community goals impacted by change, derived by prevention or treatment program results.

CONUS—Continental United States.

CPS—Child Protective Services: A generic term to describe civilian social services mandated by law with child protection responsibilities. May also be referred to as "Child Protection and Regulatory Services."

CRIMINAL HISTORY BACKGROUND CHECK (CHBC)—An investigation based on fingerprints and other identifying information obtained by a law enforcement officer and conducted through the Federal Bureau of Investigation/Identification Division (FBI-ID) of all States. An employee or prospective employee must list current and former residences on an employment application initiated through the personnel programs of the applicable Federal Agencies, as defined in Public Law 101-647 or through the personnel program of a given government contractor. All employees and DoD contract personnel involved in the provision of childcare services to children who are under 18 years of age must undergo a criminal history background check. "Child care services" is defined as child protective services, social services, health and mental health care, child (day) care, education whether directly or indirectly involved in teaching, foster care, residential care, recreational or rehabilitative programs, and detentive, correctional, or treatment services.

CSMRT: CHILD SEXUAL MALTREATMENT RESPONSE TEAM—An ad hoc committee that meets, at the call of the FAO, in response to an allegation of child sexual maltreatment.

DANGEROUSNESS—Capacity to inflict damaging or painful injuries including inflicting deadly

injury.

DCII—Defense Clearance and Investigations Index: The central Department of Defense record of investigative files and adjudicative actions such as clearances and access determinations, revocations, and denials concerning military, civilian, and contract personnel.

DEERS—Defense Eligibility Enrollment System: A central system to identify those eligible to receive services in a military treatment facility.

DEPARTMENT OF HUMAN SERVICES (DHS)—A generic term to describe civilian social service agencies with child protection responsibilities mandated by law.

DIRECTIVE—DoD Order, Regulation, or Instruction of the Military Service, major command and/or claimant or installation.

DIRECT SERVICE—Identification, diagnosis, treatment counseling, rehabilitation, follow-up, and other services given directly to maltreatment victims and offenders and their families. These services are determined locally by a multidisciplinary case management team established to assess incidents of alleged abuse, make substantiation determinations, and formulated and monitor intervention plans.

DoD—Department of Defense

DoDD:—Department of Defense Directive

DoD ELIGIBLE BENEFICIARIES—Those individuals who are authorized services in a Military Medical Treatment Facility IAW current guidelines for DEERS Eligibility.

DoD FAMILY ADVOCACY PROGRAM MANAGER—The individual appointed by the Department of Defense to oversee all the military Services' Family Advocacy Programs.

DoDI—Department of Defense Instruction

DoD-SANCTIONED FACILITY—Out-of-Home Care, the responsibility of care for and/or supervision of a child in a setting outside the child's home by an individual placed in a caretaker role sanctioned by a Military Service or Defense Agency or authorized by the Service or Defense Agency as a provider of care, such as care in a Child Development Center, school, recreation program, or family child care.

DOMESTIC VIOLENCE—Typically refers to spousal abuse. Sometimes used to refer to in a broader context for abuse of children, older people, spouses, and others in the home, usually by other members of the family or other residents. The social problem in which one's property, health, or life are endangered or harmed as a result of the intentional behavior of another family member.

ELIGIBILITY—Suitability to receive services in Military Medical Treatment facilities IAW current DEERS guidelines and AFI 41-115.

EXTRAFAMILIAL CAREGIVER—See Caregiver

FACAT: FAMILY ADVOCACY COMMAND ASSISTANCE TEAM—Is comprised of Joint Service specialists in psychology, psychiatry, criminal investigations, pediatric medicine, clinical social work, public affairs, and criminal law who are trained to respond to multiple victim child sexual maltreatment situations in DoD-sanctioned activities. (See Std M-22)

FAC-FAMILY ADVOCACY COMMITTEE—The policy-making, coordinating, recommending, and overseeing body for the installation FAP, or equivalent committee.

FAMILY ADVOCACY OFFICER (FAO)—A social worker, licensed for independent practice and

privileged in the MTF, designated to manage, monitor, and provide staff supervision of the Family Advocacy Program at the base level.

FAMILY ADVOCACY OUTREACH PROGRAM—A prevention component of the Air Force Family Advocacy Program established to function as a central focal point for family violence education and coordination and facilitation of Family Advocacy Program prevention, community collaboration and capacity building.

FAMILY ADVOCACY PROGRAM (FAP)—A program designed to address prevention, identification, clinical assessment, treatment, supportive services and follow-up evaluation for family maltreatment.

FAMILY ADVOCACY PROGRAM MANAGER—An individual designated by the Secretary of the Military Department to manage, monitor, and coordinate the Family Advocacy Program at the Service headquarters level. (AFMOA/SGZF program Chief)

FAMILY ADVOCACY PROGRAM RECORD—A 6-part folder opened when REASONABLE SUSPICION exists that a maltreatment incident has occurred.

FAMILY ADVOCACY STAFF TRAINING (FAST) COURSE—Joint-Service, multidisciplinary training course for entry-level FAP staff conducted several times a year. The Army is Executive Agent and the course is conducted by the Academy of Health Sciences. Oversight responsibility rests with the DoD Family Advocacy Program Manager.

FAMILY ADVOCACY STRENGTH-BASED THERAPY (FAST) SERVICES—Secondary prevention counseling services designed to provide psychosocial assessments and therapeutic interventions to families at risk for maltreatment where there is no open maltreatment record and the family is not eligible for New Parent Support Program.

FAMILY CHILD CARE (FCC)—Formerly referred to as family home day care. A home day care business operated on DoD property, with oversight by the installation through the Child Development Center.

FAMILY MALTREATMENT CASE MANAGEMENT TEAM (FMCMT)—A multidisciplinary team approved by the Family Advocacy Committee (FAC) working at the installation level, tasked with the clinical evaluation and incident status determination of all incidents of family maltreatment reported to the FAP. The FMCMT is also responsible for the development and coordination of overall intervention strategies and treatment recommendations for substantiated incidents.

FAMILY SUPPORT CENTER (FSC)—An Air Force installation agency that offers a variety of support services for military families (e.g., financial counseling, relocation and transition assistance, Air Force Aid).

FAMILY VIOLENCE—A generic term for all forms of intra-familial maltreatment.

FAMILY VIOLENCE EDUCATION and PREVENTION TRAINING—Refers to a unique service requirement of FAP, implemented through the Outreach Program, to ensure leadership, agency, and community awareness of dynamics, responsibilities, laws, policies, prevention and treatment associated with family violence, utilizing a consistent body of information and a systematic approach to training. Family violence education and prevention training includes fostering sensitivity and advocacy for nonviolent communities.

FAP CLINICIANS—Master-level social workers who are licensed for independent practice and

privileged in the MTF to perform clinical work.

FAPNET—The Family Advocacy multifunctional website that serves as a large resource repository and a data collection tool. FAPNET greatly enhances communication between field sites and AFMOA/SGZF.

HIGH INTEREST CASE—Child/spouse death maltreatment incidents and child sexual maltreatment in DoD sanctioned activities that require notification to AFMOA/SGZF within 24 hours of referral to Family Advocacy. The required High Interest worksheet is generated by FASOR.

HIGH VISIBILITY—A case of significant interest due to level of risk, high dangerousness/lethality potential, or political ramifications; or a case that resulted in death and/or multiple victims.

HRVRT—High Risk For Violence Response Team A multidisciplinary team established by the FAC at each installation to manage potentially dangerous situations involving FAP clients. (See Standard M-3).

HSI-HEALTH SERVICES INSPECTION—The team of inspectors from the AF Medical Inspection Agency (AFIA) from Kirtland AFB NM. Inspects and rates all AF medical treatment facilities to insure compliance with Air Force directives. Partners with the Joint Commission on Accreditation of Healthcare Organizations.

IAW—An abbreviation that means "In accordance with "

IDS—Integrated Delivery System: is a multidisciplinary team of helping professionals representing six base agencies, collaborating to provide seamless prevention and quality of life services to Air Force families and the community.

INCIDENT—A single report of one or more alleged acts of child or spouse maltreatment that occurred in close proximity of time. An incident refers to one victim and may include more than one alleged offender and/or more than one type of maltreatment.

INCIDENT STATUS DETERMINATION—The clinical status of the incident as determined by the Family Maltreatment Case Management Team. This includes "unsubstantiated - did not occur," "unsubstantiated - unresolved," or "substantiated," as follows:

- a. *Unsubstantiated - Did Not Occur*: A designation that indicates an alleged incident of child or spouse abuse has been clinically determined by the FMCMT to be without merit or foundation. An Unsubstantiated - Did Not Occur" clinical determination means that the preponderance of available information that indicates that abuse or maltreatment did not occur is of greater weight or more convincing clinically than the information that indicates that abuse or maltreatment occurred.
- b. *Unsubstantiated - Unresolved*: A designation that indicates the FMCMT clinically determined that the preponderance of the available information to support an alleged incident of child or spouse abuse or maltreatment is of the same weight or equally convincing as the information that the alleged incident of abuse or maltreatment did not occur.
- c. *Substantiated*: A designation that indicates an alleged incident of child or spouse abuse or maltreatment has been clinically determined by the FMCMT to be merited or founded. A "Substantiated" clinical determination means that the preponderance of available information that indicates that abuse or maltreatment occurred is of greater weight or more convincing clinically than the information that indicates that abuse or maltreatment did not occur.
- d. An incident status determined may be DEFERRED if an allegation needs further evaluation.

INSTALLATION RECORDS CHECK (IRC)—An investigation conducted through the records of all installations of an individual's identified residences for the 2 years before the date of application. This record check must include police (base and/or military police, security office, criminal investigations, or local law enforcement) local file check, Drug and Alcohol Program, Family Housing, and Medical Treatment Facility for Family Advocacy Program, to include Service Central Registry records and Life Skills Support Clinic records, and any other record checks as appropriate, to the extent permitted by law. (Source: AFI 34-276)

INTERDISCIPLINARY—Team intervention or collaboration that involves different professions or disciplines.

INTER-SERVICE SUPPORT AGREEMENT (ISSA)—A Memorandum of Understanding with other Uniformed Services agencies.

INTERVENTION—An action taken to promote change. Interventions may be preventive, supportive or treatment oriented for safety or to provide and represent all aspects of care.

INTRAFAMILIAL—In child maltreatment cases, the offender is a parent, or has a blood or kinship relationship to the victim. In spouse maltreatment cases, the victim is married to the offender. This includes a marriage to an individual who is under 18 years of age.

ISDR—Incident Status Determination Review. The review process, which enables FAP clients to have their substantiated cases reviewed if additional information is found and/or FMCMT procedures were not adequately followed. (See Std M-9)

ISDR REVIEWER—A member of the installation FAC designated (in writing) by the FAC chairperson to review additional information and/or FMCMT procedures that may not have followed FAP Standards during a case's initial FMCMT assessment.

JURISDICTION—Appropriate organization for management of maltreatment referrals IAW AFI 41-115 and AF FAP Standard A- 11.

JUVENILE SEX OFFENDER—An individual under the age of 18 who commits any act of sexual maltreatment while in a caretaker role or a position of power or influence over the victim.

LETHALITY—Deadly injury.

LOCAL AGENCIES—Civilian agencies located in a geographic proximity to a military installation. These include community, county, state, and federal facilities or services, other than those available on the installation.

MAJCOM—Major Command

MALTREATMENT—See definition of child or spouse maltreatment.

MALTREATMENT PREVENTION—Efforts to prevent child and spouse maltreatment; and to build resilience at the individual, unit, base, and community levels.

- a. *Primary prevention*: programs and services available to all members of the community on a voluntary basis that promote healthy family and community functioning.
- b. *Secondary prevention*: Voluntary programs and services that target the reduction of identified risk factors and the strengthening of protective factors on the individual, unit, base, and community levels.

- c. *Tertiary prevention*: Therapeutic interventions provided after an incident has occurred with the goal to prevent subsequent incidents.

MOA—Memorandum of Agreement: Agreement made between two agencies/organizations to provide services to military beneficiaries. An agreement that defines areas of responsibility and agreement between two or more parties, normally to document the exchange of services and resources.

MOU—Memorandum of Understanding: An umbrella agreement that defines areas of mutual understanding between two or more parties.

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

MULTIDISCIPLINARY—Composed or made up from several specialized branches of learning, or disciplines, for the purpose of achieving a common goal.

NEEDS ASSESSMENT—The process of identifying and evaluating persons, groups, and communities to determine their needs. This may include, but is not limited to, surveys, questionnaires, and interviews of relevant individuals, groups, helping agency experts, commanders, and military members in particular geographic areas or military ranks, and military members on special assignment.

NEGLECT—Failure to provide needed, age-appropriate care.

NEW PARENT SUPPORT PROGRAM (NPSP)—A home-based family maltreatment prevention program for at risk families who are expecting or have infants and toddlers. This home visitation program is managed by the assigned Family Advocacy Nurse. (See Standard P-10).

NRO: NO RECORD OPENED—A FAP record not opened due to lack of reasonable suspicion, ineligibility for FAP services, or jurisdictional ineligibility. With few exceptions, once a FAP provider interviews a family member, the record must be opened and a case status determination made.

OCONUS—Outside the Continental United States

OFFENDER: —See alleged offender

ON-BASE AGENCIES—Any facility or service available on-base to assist military families, such as the Medical Treatment Facility, Chapel, Air Force Aid Society, Social Actions, Family Support Center, American Red Cross, the Child Development Center, Security Forces, and Air Force Office of Special Investigations.

OPENED FAP RECORD—A FAP program record opened IAW FAP Standard M-4

OUTREACH PREVENTION LOG (OPL)—Centralized tool coordinated by the Family Advocacy Outreach Manager (FAOM) and used by the FAP team to document primary and secondary prevention activities, community organization initiatives, collaborations, prevention-focused task forces, working groups, team meetings, and annual training.

OUTREACH SERVICES—Services designed to enhance coping capacity within families that are at risk for family maltreatment, i.e. services designed to promote family wellness, maximize knowledge, skills and abilities and strengthen coping, adaptive and resilience skills.

PCS—Permanent Change of Station: change in location of home duty station.

POSITION OF POWER—Person has power over another person due to physical size, age, coercion/threats with the ability to carry out a threat etc. The position of power may occur in a single incident or be

a feature of an ongoing relationship.

PREVENTION—To avoid or inhibit negative outcomes through activities that increase education and awareness, build community cohesion and conducive culture changes, inoculate at-risk groups, and enhance autonomy or effective decision-making. Prevention includes establishing those conditions in society that enhance opportunities for individuals, families and communities to achieve positive fulfillment.

PROTECTION—Offering a form of safeguarding the victim or potential victim from physical, emotional, and sexual maltreatment or neglect.

PROTECTIVE FACTORS—Elements that promote positive behavior, health, well-being and system success. Protective factors include positive social orientation, resilient temperament positive community norms and laws, and the psychological sense of connection to one's community.

PRP—Personal Reliability Program: Cases with sponsors on PRP must be case managed IAW AFI 36-2104.

PSYCHO-EDUCATIONAL—Programs and services, which involve both psychological and social skills information, delivered in a didactic or tutoring format.

PSYCHOSOCIAL—Attending to both psychological and social dimensions when assessing or intervening with a client.

REASONABLE SUSPICION—Available information is sufficient to cause an objective individual to believe that maltreatment may have occurred by acts of commission or omission.

RECAN TATION—The victim of maltreatment (or any person professing to have observed the maltreatment) retracts or disavows his or her previous statement on the occurrence of the maltreatment.

RECIDIVISM—A repeat incident of substantiated maltreatment by the same offender that occurs anytime after closure of a prior substantiated case.

REFERRAL LOG—A mechanism to track and record data pertaining to referrals made to FAP components (i.e., Maltreatment and NPSP).

RELATED INCIDENT—An incident in an open case with the same sponsor and a different victim, offender, or both.

RESILIENCY—The ability of a system to recover, spring back, or return to previous circumstances after encountering problems or stresses. A factor to assess in planning micro-or macro-system interventions.

RISK—The potential for harm of the victim or potential victim of abuse; influenced, threatened or otherwise, without regard to whether maltreatment allegations are or can be substantiated. Exposure to the possibility of death, injury or harm. Potential harm can occur at the time of an incident, for example, when an object was thrown at, but missed the victim. Risk of further harm refers to the possibility that another maltreatment incident could occur.

RISK ASSESSMENT—A clearly-defined process that uses interviews, observations, and evidence to develop an accurate, reliable, understanding (and written description) of whether or not the victim is safe and unlikely to be harmed by the offender(s) in the near future. The risk assessment cannot definitively predict behavior, but can reduce errors in judgment and may be studied over time to lend more accuracy to predictions. Risk assessment will identify strengths as well as problems and limitations.

RISK FACTORS—Elements that increase the likelihood of an event or problem. Community risk

factors can include availability of drugs, availability of firearms, community disorganization or low neighborhood attachment.

SENSITIVE DUTY PROGRAM—SDP documentation accomplished IAW AFI 36-2104. Includes Personal Responsibility Program (PRP).

SG—Surgeon General: The Chief Medical Officer in the United States Government Public Health Service.

SHARED RESPONSIBILITY—The individual and collective acknowledgement and acceptance by community members of their responsibility to provide social support and caring for one another and their community.

SOCIAL CAPACITY—Is a community's ability to bring members together and create a psychological sense of connection in order to develop resources and opportunities for meeting the individual and collective needs and goals of its members.

SOCIAL COMPETENCE—The state of community members being properly knowledgeable and informed on social and environmental factors that impact community functioning, and having the ability to foster and contribute to community wellness.

SPOUSE—An individual who is married and: (1) a service member, (2) employed by DoD and eligible for care through DoD medical treatment programs, or (3) a civilian who is eligible for care through DoD medical treatment programs because of marriage to a service member, or to an employee of DoD who is eligible for care through DoD medical treatment programs. This includes a married individual who is under 18 years of age.

SPOUSE EMOTIONAL MALTREATMENT—Acts or threats that adversely affect the psychological well-being of a spouse, including those intended to intimidate, coerce, or terrorize the spouse. Such acts and threats include those presenting likely physical injury, property, damage or loss, or economic injury.

SPOUSE NEGLECT—The failure of a spouse to provide necessary care or assistance for his/her spouse who is incapable of self-care physically, emotionally or culturally.

SPOUSE PHYSICAL ABUSE/MALTREATMENT—Physical harm, mistreatment, or injury of a spouse by the other spouse. Acts such as grabbing, pushing, kicking, sitting or standing upon, hitting with an object and assaulting with a knife, firearm or other weapon that caused or may cause bodily injuries. Such injuries include brain damage skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts.

SPOUSE SEXUAL ABUSE/MALTREATMENT—The use of physical violence, intimidation, or explicit or implicit threat of future violence by a spouse to coerce the other spouse to engage in any sexual activity. Sexual intercourse between an alleged offender and a spouse that involves the penetration of the vagina or rectum, however slight, by means of physical force. Sexual abuse of a spouse specifically includes "Rape/Intercourse." It also includes coercing the spouse to participate in sexual activity with another person, as in pornography or prostitution.

STAFF JUDGE ADVOCATE—SJA, the Wing Commander's legal advisor who represents the government on legal matters.

SUBSEQUENT INCIDENT—Another maltreatment incident has occurred to a victim by the same offender in an existing, open case.

SUBSTANTIATED—See Incident Status Determination

TDY—Temporary Duty- Temporary assignment away from your home station.

TEAM—A group of people with a high degree of interdependence working toward the achievement of a shared/common goal.

TEAMWORK—Cooperative efforts by members of a group directed toward a common goal. Shared vision and mission, and clear roles and communication facilitate teamwork.

UNIFORM CODE OF MILITARY JUSTICE (UCMJ)—Federal laws of conduct applicable to members of the military service.

UNSUBSTANTIATED-DID NOT OCCUR—See Incident Status Determination.

UNSUBSTANTIATED-UNRESOLVED—See Incident Status Determination

USAFE—United States Air Force Europe

VOLUNTEER—Personnel recruited, screened, trained, and supervised in accordance with Standard A-27.

VWAP—Victim and Witness Assistance Program: Applies in all cases in which criminal conduct adversely affects victims or in which, witnesses provide information regarding criminal activity.

These terms and abbreviations are provided for clarity and a better understanding of the program. Sources for these definitions include DoD FAP Standards, DoDI 6400.2, DoDI 1402.5; some are common DoD and Air Force military terms.

Attachment 2

AGE GUIDELINES

0 - 5 Years Old

Parent/Caretaker can hear the child at all times and see the child frequently.

6 - 9 Years Old

Parent/Caregiver is easily accessible at all times.

***Note: Leaving a child less than 10 years old alone in a car is not appropriate.**

10 Years Old and Over

A child may be left alone if there are no emotional or physical limitations, and if the child is comfortable with the situation. *The length of time the child is left alone depends upon the child's capabilities - physically, emotionally and intellectually.*

Children of an appropriate age to be left alone should be able to demonstrate:

- a. Knowledge of where their parents or other responsible adult are, and how to reach them.
- b. Knowledge of emergency procedures.
- c. Ability to easily access and use a telephone.

GUIDELINES FOR BABY-SITTING SIBLINGS

12 - 13 Years Old

Generally able to baby-sit for family members who are at least 4 years old, *with care provided in the home of the child being supervised.*

It is highly recommended that they first successfully complete an approved baby-sitting/child care course. Contact the American Red Cross at Charleston AFB for information about course dates.

14 Years Old and Over

Generally able to baby-sit for family member infants, toddlers or older, *with care provided in the home of the child being supervised.*

Attachment 3**SPECIAL NEEDS IDENTIFICATION CRITERIA**

A3.1. Potentially life threatening conditions and/or chronic medical/physical conditions requiring intensive follow-up support (such as high risk newborns; patients with a diagnosis of cancer within last 5 years, sickle cell disease, insulin dependent diabetes) or sub-specialty care.

A3.2. Chronic (duration of 6 months or longer) mental health condition (such as bi-polar, conduct, major affective, thought or personality disorders), inpatient or intensive outpatient mental health service within the last 5 years, intensive mental health services required at the present time, including patients under the care of primary care manager or

A3.3. A diagnosis of asthma or other respiratory related diagnosis with wheezing which meets one of the following criteria:

A3.3.1. Routine use of inhaled anti-inflammatory agents and/or bronchodilators

A3.3.2. History of emergency room use or clinic visits for acute asthma exacerbation.

A3.3.3. History of one or more hospitalizations within past 5 years

A3.3.4. History of intensive care unit admissions

A3.3.5. A diagnosis of attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) that meet one of the following criteria:

A3.3.5.1. Co-morbid psychological diagnosis

A3.3.5.2. Requires multiple medications, psycho-pharmaceuticals (other than stimulants), or does not respond to normal doses of medication.

A3.3.5.3. Requires management and treatment by mental health provider (eg. Psychiatrist, Psychologist, Social Worker)

A3.3.5.4. Requires subspecialty consultants other than family practice more than twice a year on a chronic basis

A3.3.5.5. Requires modifications of the educational curriculum or the use of behavioral management staff.

A3.3.6. Requires adaptive equipment, assistive technology devices or services.

A3.3.7. Requires wheelchair accessibility/housing modifications.

A3.3.8. Has or requires Individualized Education Program (IEP).

A3.3.9. Has or requires Individual Family Service Plan (IFSP).