Davis Monthan AFB Welcome Center In-Processing Checklist

ALL APPOINTMENTS ARE ONE-ON-ONE

BLDG 3200 RM 123 DSN:228-1077

1. First Name: _____ Last Name : _____ Rank: _____
2. Last 4 SSN: _____
3. Military E-mail: _____
4. Personal E-mail Address: _____
5. Cell Phone Number: _____
6. Date Arrived on Station: _____
7. Gaining Squadron: _____ DSN: _____
8. Supervisor Name: _____ Email: _____
9. Previous Assignment, Base and SQ: _____
10. Would you like to contact the SLO (School Liaison Officer): Yes: ___ No: ___
11. Would you like to contact the EFMP Manager (Exceptional Family Member Program): Yes: ___ No: ___
12. Would you like to make an appointment with the MHO (Military Housing Office):Yes: ___ No: ___
13. ***First Duty Station Only***:
    a. DATE OF RANK(DOR): _____
    b. DATE OF BIRTH: _____
    c. Dorm Resident? Yes:___ No: ___

Spouse Information *(optional, but encouraged for non-dual mil couples)*

1. First & Last Name: _____
2. Cell Phone: _____
3. E-mail: _____
4. Would your spouse like to receive an invite to the next HeartLink Spouses Orientation (*)?
   Yes:_____No:_____
5. Can the A&FRC Spouse Employment manager email your spouse to provide program information?
   Yes:_____No:_____
6. Can the A&FRC provide your spouse's contact information to your unit Key Spouse group(**)?
   Yes:_____No:_____

* Heartlink Orientation is designed to educate new spouses on base services/programs, benefits/entitlements. Breakfast & lunch are provided. Childcare vouchers are provided at A&FRC

** The Key Spouse program is a formal commander's program that provides information and resources to military spouses and families.

Required Items for Your Welcome Center Appointment

THIS PACKET MUST BE FILLED OUT PRIOR TO APPOINTMENT

1. If this is your first duty station your supervisor/sponsor is required to accompany you to this appointment.

2. Initial Duty Assignment Worksheet (page 3) required for all. This form is completed ENTIRELY by your CSS and you need bring it to your welcome Center appointment.

3. 3 copies of your orders.

4. For **TMO** if you performed a PPM (Personally Procured Move) *AKA DITY Move*
   a. DD Form 2278, DD Form 1351-2, PPM Checklist and Expense Certification(all need to be retrieved from DPS via www.move.mil), Weight Tickets, Receipts.

   b. if You Require Postal Reimbursement DD Form 2278, DD Form 1351-2, PPM Checklist and Expense Certification(all need to be retrieved from DPS via www.move.mil), Weight Tickets, Receipts *(Must include the Weight of thePackage).*

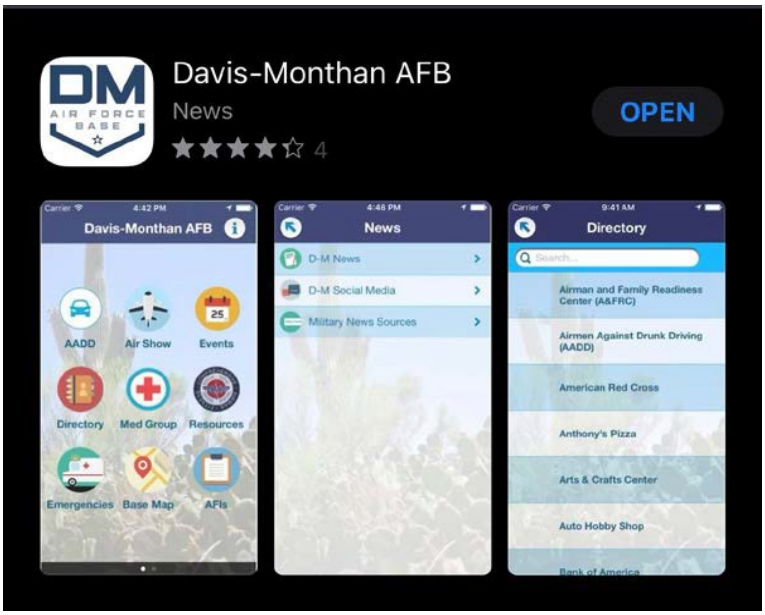
5. Medical In-Processing Packet
   a. Complete pages 4-8

6. Finance In-Processing (BRING: ALL ORDERS FRONT/BACK, RECEIPTS, KNOW EXACT DATES OF ITINERARY)

7. Fill in "PCS tool" excel product blocks 1-41c in the first green tab, then send that product to Welcome Center orgbox: 355WG.CVB.WC@US.AF.MIL (bring your CAC as you will electronically sign in person

8. If married in route a copy of your Marriage License, if divorced in route a copy of Divorce Decree.

9. Download the DM APP ***(Optional yet Highly Encouraged)***
   a. Search "**Davis Monthan AFB**" in the ***Apple™ App Store*** or ***Android™ Play Store***



Initial Duty Assignment Worksheet

Personal Data – Privacy Act of 1974 (5 U.S.C. 552a)

This form is to be completed by CSS and hand carried to Welcome Center appointment

First Name:_____Last Name:_____Rank:_____SSAN:_____

All Information listed below is required for In-Processing:

(Circle One): Active Duty AF Reserve Air National Guard

(Circle One): A = Permanent Party L= Attending TRNG PCS Status 20 weeks< Q= Pipeline

(Circle One): Were you PRP at your last base? Yes: ___ No: ___

PASCODE:_____Unit:_____RNLTD: _____

Date Arrived Station (DAS):_____Date Departed Last Duty Station (DDLDS):

Were you TDY enroute to your assignment here? Yes.__No:__ Indicate # of Days TDY_____

Position Number:_____DAFSC:_____Office Symbol:_____

Duty Title: _____

Supervisor Rank/Name/ Full SSN: _____

Do you have an EPR/OPR due? Yes:___ No: ___

If yes, was it closed out at your last duty station? _____

If no, is your EPR/OPR being actively worked at the last dutystation? _____

Special Duty Assignment Pay (SDAP) (MTI, Combat Controller, Pararescue, and Recruiter): Was SDAP paid at last duty station? Yes:___ No: ___

If yes, is member now authorized SDAP?

If no, DDLDS will be used as stop effective date.

Are you an Accession? Yes:___ No: ___

(ROTC Officer, Reserve/Guard officer or enlisted called to active duty – And this is your first duty station upon call to active duty).

A1C & Below?Yes:___ No: ___

Copy of BMT Certificate, all Tech School Certificates, and AF Form 3008. *3008 is needed for SrA as well if they have not secured their bonuses.

Does member have an UIF? _____

Date of member's last fitness assessment? _____

Have PPC's been verified? (Located on back of PCSOrders) _____

Has member's retainability been verified?_____When is the member's DOS? _____

UPC/CSS Name:_____ UPC/CSS Signature:_____

MPF Verification

Was Member Gained:_____Was sponsor removed in MilPDs:_____PT Scores Current:_____Accession:_____

IEB Verification:_____6 Yr Enlistee Verification:_____Retainability:_____PPC Verification:_____

Completed by:_____Date: _____

Occupational Health Newcomers Screener

(OPR: Public Health)

Rank:_____LAST, FIRST NAME:_____DoD ID:_____

SQUADRON:_____SHOP:_____CELL PHONE NUMBER:_____

SUPERVISORS RANK, LAST, FIRST NAME:_____

1. Does your job involve the wear of a respirator? YES___ NO ___
2. Does your work center routinely exposure you to hazardous noise requiring the use of hearing protection devices? Yes ___ No ___
3. Are you currently on a profile for pregnancy? YES___ NO ___

355 MDG Medical In-Processing Worksheet

(Completed by all Active Duty Service Members)

TO: 355 MDG Medical Management Department
FROM: Active Duty and family members Medical Needs Identification Screener
The 355 MDG makes an effort to ensure we meet the medical needs of all military personnel and family members upon relocation to Davis Monthan AFB.
In order to do this, we need to know if any special medical and/or educational needs exist for you or your family members. Please complete this form as part of your relocation medical in-processing, for yourself and dependents.

Your Name (Last, First, MI) _____ Rank _____ DoD ID _____

Home Telephone Number _____ DOB _____ Previous Duty Station _____ Current Unit _____

Local/Current Address _____

Check all that apply: AD: ___ Reserve: ___ Retired: ___ PCS: ___ TDY: ___ Separation/Retiring: ___ Dependant: ___

Please read and check the appropriate response for all questions. Thank you.

1. Do you have dependents who have accompanied you to Davis Monthan Air Force Base or will join you later? Yes :___ No: ___ N/A: ___
2. Are you currently enrolled in any service's Exceptional Family Member Program (EFMP)? Yes :___ No: ___ N/A: ___
3. Have you completed or are you in the process of completing a Family Member Relocation Clearance (FMRC) for dependents enrolled in Exceptional Family Member Program (EFMP) or Educational and Developmental Interventional Services (EDIS)? Yes :___ No: ___ N/A: ___
4. Do you or your dependents have Asthma, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD)? Yes :___ No: ___ N/A: ___
5. Do you or any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist or therapist that requires a referral? Yes :___ No: ___ N/A: ___
6. Have you or any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than six times in the last year: Yes :___ No: ___ N/A: ___
7. Do any of your dependents receive Education Services or therapy? Yes :___ No: ___ N/A: ___
8. Are you or any of you family members enrolled in Disease Management or Case Management? Yes :___ No: ___ N/A: ___
9. Are you assigned to EOD, PRP, PRAP, Mobility Status, AoU, Flying Status or Fire Fighter? Yes :___ No: ___ N/A: ___
10. If you answered yes to question 8, please specify_____
11. Circle PCM Specialty Family Practice / Flight Medicine

If you answered yes to any of the above questions, a clinical representative of the 355 Medical Group will contact you to assist you in transitioning you and/or your family member's medical care to the local area.

I understand that insufficient and/or inaccurate information may delay management and treatment of existing medical conditions.

Sponsor Signature:_____ Date: _____

Type AUTHORITY: 10 U.S.C. 55. 10 U.S.C. 8013 AND E.O. 9397 (SSN) as amended. PURPOSE(S): Used to document, plan, and coordinate the health care of Active Duty and family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data. ROUTINE USE: Used to accumulate information for determining Active Duty and family member's care when transitioning to new locations.

AIR FORCE SPECIAL NEEDS SCREENER

(Completed by all Sponsors with Family Members)

AUTHORITY: 10 U.S.C. 55. 10 U.S.C. 8013 and E.O. 9397 (SSN) as amended.

PURPOSE(S): Used to document, plan, and coordinate the health care of family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data.

ROUTINE USE: Used to accumulate information for determining family member special needs.

DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of family member's suitability for relocation at government expense or delay issuance of PCS orders.

TO: SPECIAL NEEDS COORDINATOR AND AIR FORCE PERSONNEL CENTER (AFPC)

FROM: Air Force Family Member Special Needs Identification Screener

The Air Force makes an effort to ensure specialized medical and educational services are available for all military family members. In order to help us do this, we need to know if any special medical and/or educational needs exist for your family members. You are required to complete this form as part of your relocation processing, if you have family members, whether they are living with you or not.

SPONSOR'S INFORMATION

Sponsor's Name *(Last, First, MI)* _____ Rank _____ Social Security Number *(SSN)* _____

Current Unit and Duty Station _____ Duty Telephone Number _____ Home Telephone Number _____

Projected Installation For Relocation _____ Projected Departure Date _____

SPONSOR'S FAMILY INFORMATION

Please read and answer all questions. Indicate (X) the appropriate box. **Thank you.**

1. Are your currently enrolled in any Service's Exceptional Family Member Program (EFMP)?	Yes	No
	If yes, stop here.	
2. Do any of your children receive Special Education Services?	Yes	No
3. Do any of your children receive Early Intervention Services?	Yes	No
4. Do any of your children receive speech therapy, occupational therapy, physical therapy, or counseling services?	Yes	No
5. Has any dependent member of your family been hospitalized for the same condition more than once?	Yes	No
6. Has any dependent member of your family been seen by a medical provider or mental health provider for the same condition more than six times in the last year?	Yes	No
7. Do any of your family members have a chronic medical condition that requires at least annual evaluation or follow-up by a specialist (such as cardiology, internist, psychology, neurology, counseling, etc.)?	Yes	No
8. Do any of your dependent family members have reactive airway disease or asthma?	Yes	No

If YES to any questions numbered 2 - 8, please contact the Exceptional Family Member Program (EFMP-M) Office at the Military Treatment Facility for assistance prior to pursuing any further relocation actions.

I certify that this information is complete and accurate to the best of my knowledge. I understand that insufficient and/or inaccurate information may affect family member travel at government expense. I understand that making a knowing and willful false official statement can be punishable by fine or imprisonment. (See U.S. Code, Title 18, Section 1001; Title 10, Section 907; Article 107 UCMJ).

Sponsor's Signature _____ Date _____

ACTIVE DUTY MEMBERS PLEASE COMPLETE FOR TRANSFER OF TRICARE

These forms each go to different offices. Please fill in all information. Thank you.

AD MEMBER'S NAME (Last, First, Middle Initial) (Must match DEERS)

_____

AD MEMBER'S SOCIAL SECURITY NUMBER

_____

AD MEMBER'S TELEPHONE NUMBER – CP OR HP_____WP_____

AD MEMBER'S DATE OF BIRTH (YYYYMMDD) _____

AD MEMBER'S ***LOCAL*** RESIDENTIAL ADDRESS (Street, Apt #, City, State, Zip Code)

_____

_____

IF YOU DO NOT HAVE A RESIDENTIAL ADDRESS YET, ENTER IN GENERAL DELIVERY (P.O. BOX 80001, TUCSON, AZ 85707)

AD MEMBER'S UNIT _____

ARE YOU ON FLYING STATUS: YES NO

CIRCLE PCM SPECIALTY: FAMILY PRACTICE OR FLIGHT MEDICINE

NOTE: TO ENROLL/TRANSFER FAMILY MEMBERS IN A TRICARE HEALTH PLAN, CONTACT HEALTH NET FEDERAL SERVICES (HNFS) @ 1-844-866-9378 UPON ARRIVAL. (**YOU HAVE 90 DAYS TO DO THIS)** IF YOU SELECT TRICARE PRIME & RESIDE WITHIN A 30 MINUTE DRIVE TIME FROM DAVIS-MONTHAN AFB, YOUR SPOUSE/CHILDREN (16 Y/O & OLDER) WILL BE ASSIGNED TO DAVIS-MONTHAN'S MILITARY TREATMENT FACILITY/FAMILY MEDICINE; 15 Y/O AND BELOW WILL BE ENROLLED TO A PROVIDER AT THE BASE PEDIATRIC CLINIC. IF YOUR FAMILY RESIDES OVER 30 MINUTES DRIVE TIME FROM THE BASE, AND THEY WISH TO BE ENROLLED IN TRICARE PRIME, THEY MAY SELECT EITHER ON BASE OR OFF BASE PCM. YOU WILL NEED TO LET HNFS KNOW EITHER WAY. FOR OFF BASE PCMS, GO TO WWW.TRICARE-WEST.COM, CLICK ON BENEFICIARY, PROVIDER DIRECTORY TO LOCATE A LIST. MAKE SURE YOU CONTACT THE DOCTOR'S OFFICE TO MAKE SURE THEY ARE STILL ACCEPTING NEW PATIENTS. ONCE DECIDED ON, CALL HNFS AT 1-844-866-9378 TO MAKE THE CHANGE. MAKE SURE YOU UPDATE YOUR LOCAL ADDRESS.

PCS Voucher Instructions

FINANCE VOUCHER WILL BE COMPLETED AT WELCOME CENTER ONE-ON-ONE

MAKE SURE YOU BRING:

- ALL pages of your orders, including any amendments and in-lieu memorandum (if put in quarantine)
- All receipts for expenses you plan to claim (paper copy).
    - Air Fare
    - Lodging
    - Amounts Over 75$
- Be prepared to provide exact dates for your entire itinerary (TDY, Leave , Ports).

- *NEW* To complete your travel voucher you must fill out the applicable portions of lines 1-41c of the Customer Interface tab on "PCS tool" excel product. THEN email that excel product to 355WG.CVB.WC@US.AF.MIL (excel product is located in the in-processing documents tab on the SharePoint)

- Page 13 Direct Deposit Form (Everyone Must Complete)
-     - Complete Sections 1 and 5 sign and date

FASTSTART DIRECT DEPOSIT

INSTRUCTIONS FOR PROCESSING FEDERAL EMPLOYEE PAYMENTS

Use: For processing Federal employee net salary, allotments, and other agency - approved payments associated with Federal employment (i.e. travel reimbursement, uniform allowance, etc). Employee must complete items 1,2,3 and 5. Complete item 4 only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.

1. EMPLOYEE INFORMATION

(SSN) EMPLOYEE PAYROLL IDENTIFICATION NUMBER

EMPLOYEE NAME
(as on payroll records)
(Last, First, Initials)

TELEPHONE NUMBER (WORK) (HOME)

2. TYPE OF ACCOUNT

- ☐ Checking
- ☐ Savings

TYPE OF PAYMENT

- ☐ Net Pay
- ☐ Travel
- ☐ Other Federal employment related payments

3. DIRECT DEPOSIT ACCOUNT INFORMATION - NET PAY/TRAVEL/OTHER (Use Sec. 4 for allotments)
A voided personal check/sharedraft may be attached in lieu of completing this section.
See instructions on back of this form.

ROUTING TRANSIT NUMBER
Check Digit

ACCOUNT NUMBER

ACCOUNT TITLE **SAME AS MMPA**
(Account Holder's Name)

FINANCIAL INSTITUTION NAME

4. ALLOTMENT INFORMATION
Complete this section only if you want to start, cancel or change the amount of a savings or discretionary allotment - see instructions on back of form.

TYPE OF ALLOTMENT (Check One)
- ☐ Savings (whole dollar amounts only)
- ☐ Discretionary or Third Party

TYPE OF ACCOUNT (Check One)
- ☐ SAVINGS
- ☐ CHECKING

ACTION (Check One)
- ☐ START
- ☐ CANCEL
- ☐ CHANGE

AMOUNT (Check One)
- ☐ INCREASE TO:
- ☐ DECREASE TO:

New Total $

ALLOTTEE NAME
(person/company who will receive allotment)

ALLOTTEE'S ROUTING NUMBER
Check Digit

ALLOTTEE'S ACCOUNT NUMBER

ALLOTTEE'S ACCOUNT TITLE
(Account Holder's Name)

FINANCIAL INSTITUTION NAME

5. AUTHORIZATION

✻ EMPLOYEE'S SIGNATURE DATE

6. AGENCY USE: