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Davis Monthan AFB Welcome Center In-Processing Checklist

ALL APPOINTMENTS ARE ONE-ON-ONE

BLDG 3200 RM 123 DSN:228-1077

1. LAST, FIRST, MI_____ Rank: _____
2. Full SSN: _____ DOD ID Number:
3. Military E-mail: _____
4. Personal E-mail Address: _____
5. Personal Cell Phone Number: _____
6. Date Arrived on Station: _____
7. Gaining Squadron:_____ DSN: _____
8. CSS member's email: _____
9. Supervisor Name: _____Email: _____
10. Previous Assignment, Base and SQ: _____
11. Would you like to contact the SLPM (School Liaison/Prek-12): Yes: No:
12. Would you like to contact the EFMP Manager (Exceptional Family Member Program): Yes: No:
13. Would you like to make an appointment with the MHO (Military Housing Office):Yes: No:
14. ***First Duty Station Only***:
    a. DATE OF RANK(DOR):_____
    b. DATE OF BIRTH: _____
    c. Dorm Resident? Yes: No:
15. Will you require a meeting with TMO? Yes: No:

(Please see yellow comment box for required items)

Military & Family Readiness Center

1. Will you be retiring or separating within the next 18 Months? Yes: No:
2. Do you have an immediate need for financial assistance or financial guidance? Yes: No:
3. Do you expect to deploy within the next 6 months? Yes: No:
4. Are you seeking relationship enhancement services (couples communication, counseling)? 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. Will your spouse be seeking employment? Yes: No:
6. Can the M&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 provide Childcare vouchers are provided at M&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 (pg. 9). *This form is completed ENTIRELY by your **CSS** (for input in MiLPDS).*

3. *Send a digital copy of your orders from VMPF to your CSS & bring 2 physical copies to your appointment.*

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 HTTPS://www.militaryonesource.mil/moving-pcs/moving-personal-property/), Weight Tickets, **Receipts** (rented equipment, gas receipts for vehicles driven/rented, packaging materials like boxes/bubble wrap/etc., contractors/hired moving hands).

    b. If you Require Postal Reimbursement DD Form 2278, DD Form 1351-2, PPM Checklist and Expense Certification (all retrieved from DPS (www.militaryonesource.mil), Weight Tickets, Receipts *(Must include the Weight of the Package).*

5. Medical In-Processing Packet, **SIGN ALL FORMS *YOU ARE THE SPONSOR**
    a. Pages 3-6
    b. Fill out all forms COMPLETELY, otherwise you will not be properly medically in-processed.
6. Finance In-Processing (BRING: ALL ORDERS FRONT/BACK, RECEIPTS, KNOW EXACT DATES OF ITINERARY)

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

8. Download the AF CONNECT APP ***(Optional yet Highly Encouraged)***
    a. Search "**AF Connect**" in the ***Apple™ App Store*** or ***Android™ Play Store***
    b. Look for 355th Fight Wing

AF CONNECT APP

Notifications regarding the base, such as road conditions and delayed reporting, are relayed through the AF Connect App.

The app can be downloaded for free through the Apple App Store or Google Play Store. Here is a tutorial on how to set the **355th Fighter Wing** as your primary page.

GET IT ON Google Play

Download on the App Store

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 **DATE OF BIRTH** Previous Duty Station Current Unit

Local/Current Address _____

Check all that apply: AD: ☐ Reserve ☐ Retired: ☐ PCS: ☐ TDY: ☐ Separation/Retiring: ☐ Dependent: ☐

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.

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.

Personal Data, Privacy Act of 1974 as amended applies. This may contain information which may be protected IAW DoD 5400.11R and is For Official Use Only (FOUO)

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 DOD ID # BENEFITS DOD ID #

_____ _____ _____

AD MEMBER'S TELEPHONE NUMBER – CP OR HP_____ WP_____

AD MEMBER'S DATE OF BIRTH (YYYYMMDD) _____

MANDATORY INFORMATION FOR REGISTRATION INTO YOUR MEDICAL RECORD IN MILITARY HEALTH SYSTEM (MHS) GENESIS:

RACE: _____

ETHNICITY: CIRCLE WHICH IS APPLICABLE ◯ HISPANIC/LATINO or ◯ NOT HISPANIC/LATINO

PREFERRED LANGUAGE: _____ IF NOT ENGLISH IS INTERPRETER REQUIRED? YES OR NO

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 _____ AFSC _____

ARE YOU ON FLYING STATUS: YES ☐ NO ☐ ASSIGNED TO 355 CES/EXPLOSIVE ORDINANCE DISPOSAL (EOD): YES ☐ NO ☐

CIRCLE PCM SPECIALTY: ◯ FAMILY PRACTICE OR ◯ FLIGHT MEDICINE

NOTE: TO ENROLL/TRANSFER FAMILY MEMBERS IN A TRICARE HEALTH PLAN, CONTACT TRIWEST HEALTHCARE ALLIANCE @ 1-888-874-9378 UPON ARRIVAL. (**YOU HAVE 90 DAYS TO DO THIS- DO THIS IMMEDIATELY). REMEMBER TO UPDATE YOUR ADDRESS IN DEERS.**

TRICARE PRIME OPTION: IF YOU RESIDE WITHIN A 30 MINUTE DRIVE TIME FROM THE BASE, YOUR SPOUSE AND CHILDREN WILL BE ASSIGNED AN ON BASE PROVIDER. IF YOU RESIDE OVER THE 30 MINUTE DRIVE TIME THEN YOUR FAMILY CAN EITHER CHOSE AN ON BASE OR OFF BASE PRIMARY CARE PROVIDER. (UP TO 100 MILES)

TO LOCATE OFF BASE PCMs, Go to www.tricare.mil/west & click on find a doctor, choose a location and plan (enter in your address or zip code, confirm that this is correct) then search for a TRIWEST network provider – go to doctors by specialty and type in primary care manager and you will get a list. Call and see who is accepting new patients and how far out they are booking for a new patient. ONCE DECIDED ON, CALL TRIWEST HEALTH CARE ALLIANCE 1-888-874-9378 TO MAKE THE CHANGE. Make sure you call back to your new PCM and make an appointment to been seen right away.

TRICARE SELECT OPTION: Family members will have their health care off base normally with network providers/doctors. You will have deductibles and co-payments every time you see a provider/doctor. Call TriWest Healthcare Alliance 1-888-874-9378 to make the change and update your address. You will not see a provider on base. Make sure you call the provider right way to schedule an appointment.

Go to www.tricare.mil for more information on the TRICARE Health Plans. For additional questions, please call our Health Benefits Advisors – Mr. Bill Howard/ 520-228-2634 or Mrs. Patrice Ross/520-228-1525

Personal Data, Privacy Act of 1974 as amended applies. This may contain information which may be protected IAW DoD 5400.11R and is For Official Use only (FOUO)

PCS Voucher Instructions

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

MAKE SURE YOU BRING:

- PCS orders and amendments

- Receipts related to your move: (Without hard copies of the required documents, you won't be able to complete your travel voucher and will need to return to the finance office during customer service hours later (Monday, Wednesday, Friday 0900-1500)).
    - Airfare
    - Lodging
    - Pet Expenses
    - Taxi
    - Any additional expenses over $75 will require receipt

- List exact dates for your entire itinerary (TDY, Leave , Ports).

- Ensure you have filled out the two GREEN tabs, Customer Interface and Customer Travel Interface, on the PCS Tool Excel spreadsheet that was sent to you to the best of your ability. Finance will go over it with you to confirm everything.

Initial Duty Assignment Worksheet

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

This form must be fully completed before being returned to the Welcome Center Org Box

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: _____