Forms available on the iPort: State Surgeon→ Case Management→ Documents (individual forms are listed)
On the Internet: www.idahoarmyguard.org→ National Guard HRO→ AGR Section→ AGR Section→ Medical→ Case Mgmt Profile Guide

IDAHO ARMY NATIONAL GUARD
OFFICE OF THE STATE SURGEON
4228 W. GUARD ST, BLDG 665
BOISE, ID 83705-8049
Fax: 208-272-3769
charlene.stevens@id.ngb.army.mil
sid.skene@id.ngb.army.mil

HOW TO OBTAIN A PROFILE
&
CASE MANAGEMENT (CM) PROCEDURES

1. Traditional **(M-Day)** soldiers are case managed by **Char Stevens, RN (208-272-3725).**
2. For **Active Duty** soldiers (AGR, ADSW, etc), please contact **SFC Laura Skene (208-272-3776).**
3. To obtain a temporary or permanent profile, the following documentation must be provided:

   ☐ ***A.*** All current (within the last 2-3 months) medical providers' chart notes related to the condition.

   ☐ ***B.*** All diagnostic testing reports (x-rays, MRIs, labs, etc) related to the condition.

   ☐ ***C.*** A completed Limitations form for Basic Soldier Skills and Physical Fitness testing (available from CM or online) **or** documentation from the medical provider listing specific limitations. Limitations for a permanent profile must be from an M.D. or D.O.

   ☐ Submit all documentation ***(A, B, C)*** to appropriate Case Manager in Bldg. 665 or fax / email to numbers listed above. When all documentation has been received, it will be reviewed IAW AR 40-501 and a temporary or permanent profile will be prepared.

4. **The process of obtaining a profile is not immediate.** The profile is entered into the MND module where it is reviewed and electronically signed by a physician profiling officer. This process may take only a few days or up to a couple of weeks. A permanent profile will take longer because it requires two signatures.
5. When the process of obtaining a profile signature is delayed, the soldier may present to the unit a copy of the documentation from their provider listing their limitations (IAW AR 40-501, chapter 10, paragraph 15).
6. After the profile is signed, a copy is forwarded to the unit commander. The soldier should receive a copy from their unit. It is also available online in the MND module.
7. Temporary profiles are issued a maximum of 90 days at a time (up to 12 months total). They are reviewed and signed by a physician profiling officer as they come due, provided updated documentation has been received. If updated documentation has not been received when the temporary profile expires, the soldier will be discharged from CM and revert to their previous permanent profile or a new permanent profile will be issued and, depending on the circumstances, a medical board may be initiated.
8. After 12 months on a temporary profile, the medical condition is reviewed and the profile will usually become a permanent profile at that time.
9. Case Managers must be kept regularly informed of progress and all scheduled appointments including surgery dates. Provide CM with the most current medical notes after each appointment.
10. For convenience, soldiers may complete and sign a consent form (DD 2870) to release information to Case Management (form available from CM, online, or in the provider's office). This will enable documentation to be faxed directly to CM from the provider after the appointment.
11. **Keep contact information current** with Case Management, including phone numbers (home, work, cell, fax, etc), email address, home address, and unit assigned to.

SOLDIER LIMITATIONS FORM

SOLDIER NAME _____ **SSN:** _____

Below you will find a list of Basic Soldier Skills and Physical Fitness Testing. Please clarify the soldier's limitations by completing this form and **accompany it with your current progress notes that support the limitations**. For the Basic Soldier Skills, we need to know how fit the soldier is to perform the skills when under fire. For all "no" answers, please indicate in the far right column
T for temporary restriction (expected to last less than 1-year) **with an estimated recovery time** or
P for permanent restriction (expected to last over 1-year).

BASIC SOLDIER SKILLS	YES	NO	(P = permanent) (T = temporary) and Estimated Recovery Time
1. Able to **physically & mentally** carry & fire assigned weapon (recoil and minimum 8 pounds in weight)?			
2. Able to move with a "fighting load" (48 pounds) at least 2 miles? (includes Kevlar helmet – 3 pounds)			
3. Able to wear protective mask and all chemical defense equipment?			
4. Able to construct an "individual fighting position" (dig, fill & lift sand bags, etc)?			
5. Able to run 3-5 seconds, fall to the ground & jump up repeatedly while under enemy weapon fire?			
6. Is soldier **physically & mentally** healthy with no medical condition that prevents worldwide deployment?			
PHYSICAL FITNESS TESTING			
1. Able to perform timed **sit-ups** test event?			
2. Able to perform timed **push-ups** test event?			
3. Able to perform **upper body weight training**?			
4. Able to perform **lower body weight training**?			
5. Able to perform a timed **2-mile run** test event?			
6. If unable to perform a timed 2-mile run test event, is the soldier able to do at least one of the following?			
a. Able to perform 2 1/2 mile timed **walk** event?			
b. Able to perform an aerobic **swimming** timed test?			
c. Able to perform aerobic **bicycling** timed event?			
7. Mark each of the following as it applies to this soldier. Mark **YES or NO** next to each skill:			
a. Unlimited running? _____ **OR** Run at own pace and distance? _____			
b. Unlimited walking? _____ **OR** Walk at own pace and distance? _____			
c. Unlimited biking? _____ **OR** Bike at own pace and distance? _____			
d. Unlimited swimming? _____ **OR** Swim at own pace and distance? _____			
8. Does this soldier require medication for control of any condition / disease / injury?			

DIAGNOSIS: _____

MEDICATIONS: _____

ADDITIONAL LIMITATIONS: _____

PROGNOSIS / PLAN OF CARE: _____

_____

_____

_____ _____

PHYSICIAN'S SIGNATURE DATE

PLEASE RETURN ALL FORMS AND MEDICAL DOCUMENTATION BY FAX, E-MAIL, OR MAIL TO:
Office of the State Surgeon, Idaho Army National Guard, 4228 W Guard St., Bldg. 665, Boise, Idaho 83705-8049

Char Stevens, RN - State Medical Case Manager **(M-DAY)**
Phone: 208-272-3725 FAX: 208-272-3769
charlene.stevens@id.ngb.army.mil

SFC Laura Skene **(AGR)**
Phone: 208-272-3776 FAX: 208-272-3769
sid.skene@id.ngb.army.mil

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

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

SECTION I - PATIENT DATA

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

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

SECTION II - DISCLOSURE

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

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
State Medical Case Manager Idaho Army National Guard	4228 W Guard St., Bldg 665 Boise, Idaho 83705-8049
c. TELEPHONE *(Include Area Code)* 208-272-3725	d. FAX *(Include Area Code)* 208-272-3769

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

☐ PERSONAL USE	☐ CONTINUED MEDICAL CARE	☐ SCHOOL	☒ OTHER *(Specify)*
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	to determine medical status for the military

8. INFORMATION TO BE RELEASED
To aid in determining limitations, deployability, or retainability with the military, please include all medical information requested and results of diagnostic testing.

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

SECTION III - RELEASE AUTHORIZATION

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

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

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

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

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