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

1. M-DAY, AGR & ADOS soldiers are case managed by Char Stevens, RN (208-272-3725).

2. All Soldiers on Flight status are case managed by MAJ Munro (208-272-4145).

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 ACTIVITY RESTRICTIONS form for Basic Skills and Physical Fitness testing (available from CM or on the iPort) or documentation from the medical provider listing specific limitations. (Limitations for a permanent profile must be from an M.D. or D.O.)
     NOTE: A Chiropractor is not an M.D. or D.O.
   - Submit all documentation (A, B, C) to Case Mgmt Medical Admin in Bldg. 665 or fax to number 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. If this is IN LINE OF DUTY (LOD) soldier MUST contact his/her unit to initiate the LOD process.

5. The process of obtaining a profile is not immediate. The profile is entered into the e-Profile module where it is reviewed and electronically signed by a profiling officer. This process may take several days. A permanent profile will take longer because it requires two signatures.

6. 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 restrictions (IAW AR 40-501, chapter 10, paragraph 15).

7. After the profile is signed, a copy is forwarded to the unit along with a copy for the soldier. It is also available (to the unit) online in e-Profile and to the soldier on the Medical Readiness page in AKO.

8. 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 showing ongoing treatment has been received. If updated documentation has not been received, 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.

9. After 12 months on a temporary profile, the medical condition is reviewed and the profile will usually become a permanent profile at that time.

10. When a temporary profile has been lifted or expired, the soldier must be given twice the length of the profile (not to exceed 90 days) to train for the regular APFT (IAW TC 3-22.20, A-41).

11. 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.

12. For convenience, soldiers may complete and sign a consent form (DD 2870) to release information to Case Management (form available from CM, on the iPort, or in the provider’s office). This will enable documentation to be faxed directly to CM from the provider after the appointment.

13. Keep contact information current with Case Management, including phone numbers (home, work, cell, fax, etc), email address, home address, and unit assigned to.
## CASE MANAGEMENT SOLDIER CONTACT SHEET

### Personal Information:
- **Full Name**
- **Rank**
- **SSN**
- **Home address**
- **Home phone**
- **Cell phone**
- **E-mail address**
- **Date of birth**

### Unit Information:
- **UIC**
- **Company**
- **Commander**
- **Readiness NCO**
- **Unit phone**

### CM Information: (Case Management to complete this section)
- **ROI signed:** Y / N
- **CM Counseling done:** Y / N
- **CM packet given to SM:** Y / N
- **Temp Profile issued:** Y / N **Date issued:**
- **Current Perm Profile:** Y / N **Date issued:**
- **SM already in CM:** Y / N

### Referral Information:
<table>
<thead>
<tr>
<th>Hearing: Does SM wear Hearing Aids</th>
<th>Y / N</th>
<th>Sprint:</th>
<th>Y / N</th>
<th>Comprehensive Eval:</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Health:</td>
<td>Y / N</td>
<td>Pap:</td>
<td>Y / N</td>
<td>Mammogram:</td>
<td>Y / N</td>
</tr>
<tr>
<td>Cardiology:</td>
<td>Y / N</td>
<td>Stress Test:</td>
<td>Y / N</td>
<td>Echocardiogram:</td>
<td>Y / N</td>
</tr>
<tr>
<td>Supporting Documentation:</td>
<td>Y / N</td>
<td>Attached:</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LINE OF DUTY:</strong></td>
<td>Y / N</td>
<td>Date of Injury:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACTIVITY RESTRICTIONS

NAME ____________________________ SSN ___________ DOB ___________

Since restrictions for military activities differ from those of regular employment, we kindly ask that you answer the following questions as they apply to the condition you are treating. This will be communicated to the non-medical commanders who rely on the medical information to make informed decisions about a soldier's capability to accomplish certain duties or tasks as well as those specific activities the soldier is physically and mentally able to do. Activities that would reasonably be expected to cause a worsening of the condition or compromise the safety of the soldier or others should be marked “no”. Inconvenience, soldier preference, or discomfort that is no different from that of non-restricted soldiers should not be considered. (THIS IS NOT A REQUEST TO DETERMINE A SOLDIER’S ABILITY TO REMAIN IN THE MILITARY. FITNESS FOR DUTY DETERMINATION IS AN ARMY FUNCTION). Thank you for assisting our civilian soldier in the Idaho Army National Guard to be medically prepared to serve our country and state.

BASIC SKILLS Is the patient able to do the following?

1. Physically and Mentally carry and fire a weapon (recoil & minimum 8# weight) _____ □yes □no
2. Ride in a military vehicle for extended periods of time ___________________________ □yes □no
3. Wear a helmet (3#) ___________________________ □yes □no
4. Wear military boots and uniform ___________________________ □yes □no
5. Wear protective mask and chemical defense equipment ___________________________ □yes □no
6. Wear body armor and load bearing equipment (45#) ___________________________ □yes □no
7. Move 40# while wearing protective gear ___________________________ □yes □no
8. Is this soldier perceived as a threat or potential risk to themselves or others? _____ □yes □no

Are these restrictions temporary? ______________________________________ ___________

If yes, indicate estimated length of time ____________________________________________

Are these restrictions permanent or expected to last more than 1 year? ___________ □yes □no

PHYSICAL FITNESS TESTING Is the patient able to do the following?

1. Timed sit-ups test ___________________________ □yes □no
2. Timed push-ups test ___________________________ □yes □no
3. Timed 2-mile run ** ___________________________ □yes □no

** If unable to perform a 2-mile run, can the patient perform one or more of these alternate events?
Timed 2.5 mile walk □yes □no
Timed bicycle test □yes □no
Timed swimming test □yes □no

Are these restrictions temporary? ______________________________________ ___________

If yes, indicate estimated length of time ____________________________________________

Are these restrictions permanent or expected to last more than 1 year? ___________ □yes □no

Is the patient able to perform duties such as data entry, filing, and faxing until recovered? _____ □yes □no
Is the patient physically and mentally able to attend monthly drills and annual training if activities are kept within the restrictions listed? □yes □no If no, indicate reason ____________________________

Please list any medications that may impair alertness or limit performance __________________________________________

DIAGNOSIS __________________________________________

ADDITIONAL RESTRICTIONS __________________________________________

PROGNOSIS / PLAN OF CARE __________________________________________

PROVIDER’S PRINTED NAME ____________________________ PHONE ____________________________

PROVIDER’S SIGNATURE ____________________________ DATE ____________________________

PLEASE RETURN FORM AND COPY OF CHART NOTES BY FAX: 208-272-5897 EMAIL: charlene.stevens@ng.army.mil OR MAIL TO: IDAHO ARMY NATIONAL GUARD, OFFICE OF THE STATE SURGEON ATTN: CASE MANAGEMENT, 4228 W. GUARD ST, BLDG 665, BOISE, ID 83705 For questions, please contact: Char Stevens, RN, State Case Manager Phone: 208-272-3725
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

<table>
<thead>
<tr>
<th>1. NAME (Last, First, Middle Initial)</th>
<th>2. DATE OF BIRTH (YYYYMMDD)</th>
<th>3. SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)</th>
<th>5. TYPE OF TREATMENT <em>(X one)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________ and ongoing</td>
<td>OUTPATIENT</td>
</tr>
</tbody>
</table>

SECTION II - DISCLOSURE

<table>
<thead>
<tr>
<th></th>
<th>TO RELEASE MY PATIENT INFORMATION TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN</td>
<td>b. ADDRESS (Street, City, State and ZIP Code)</td>
</tr>
<tr>
<td>Idaho Army National Guard - Office of the State Surgeon</td>
<td>4228 W Guard St., Bldg 665</td>
</tr>
<tr>
<td>attn: Char Stevens, Medical Case Management</td>
<td>Boise, Idaho 83705-8049</td>
</tr>
<tr>
<td>c. TELEPHONE (Include Area Code) 208-272-3725</td>
<td>d. FAX (Include Area Code) 208-272-5897</td>
</tr>
</tbody>
</table>

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

- PERSONAL USE
- CONTINUED MEDICAL CARE
- SCHOOL
- RETIREMENT/SEPARATION
- LEGAL
- OTHER *(Specify)*

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)

SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

12. RELATIONSHIP TO PATIENT *(If applicable)*

13. DATE (YYYYMMDD)

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

14. X IF APPLICABLE: AUTHORIZATION REVOLED

15. REVOCATION COMPLETED BY

16. DATE (YYYYMMDD)

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE

SPONSOR NAME:

SPONSOR RANK:

FMP/SPONSOR SSN:

BRANCH OF SERVICE:

PHONE NUMBER:

DD FORM 2870, DEC 2003
Printing a Profile in AKO My Medical Readiness

After a profile is signed and approved a Soldier will be able to print a copy of their profile from the My Medical Readiness page in AKO.

Please follow these steps:

1) Logon to AKO
2) Click on the “My Medical Readiness Status” on the right side of your AKO homepage

3) On the Medical Readiness page you will see the My Medical Readiness on the right side. Click on any “View Detailed Information” link.

4) A separate web page will open displaying the Soldier’s Medical Readiness. Click on the “Download My Profiles (DA 3349)” link near the bottom left hand side of the page.

5) Another web page will open showing all of the approved permanent and temporary profiles on the Soldier. Click on “View PDF” for the appropriate profile.

6) Click “OK” on the dialog box that opens

7) Preview the profile on the screen and click on the Printer icon in the top left hand corner to print or save a copy by using the file menu