DEVELOPMENTAL COUNSELING FORM

For use of this form, see ATP 6-22.1; the proponent agency is TRADOC.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 301, Departmental Regulations, 10 USC 3013, Secretary of the Army.

PRINCIPAL PURPOSE: These records are created and maintained to manage the member's Army and Army National Guard service effectively, to document historically a member's military service,and safeguard the rights of the member and the Army.

NOTE: For additional information, see the System of Records Notice A0600-8-104b AHRC, https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570051/a0600-8-104b-ahrc/.

ROUTINE USE(S): There are no specific routine uses anticipated for this form; however, it may be subject to a number of proper and necessary routine uses identified in the system of records notice specified in the purpose statement above.

DISCLOSURE: Disclosure is voluntary.

PART I - ADMINISTRATIVE DATA

Name *(Last, First, MI)*	Rank/Grade	Date of Counseling

Organization	Name and Title of Counselor

PART II - BACKGROUND INFORMATION

Purpose of Counseling: *(Leader states the reason for the counseling, e.g. Performance/Professional/Event-Oriented counseling, and include the leader's facts and observations prior to the counseling.)*

Approach: ☐ Non Directive ☐ Combined ☐ Directive

Type of Counseling: ☑ General Form ☐ Professional Growth ☐ Performance ☐ Event Oriented

The purpose of this counseling is to voluntarily place (Soldier Name) on 12301(h) orders to receive medical treatment or evaluation for injuries, illness, or disease incurred in the line of duty.

PART III - SUMMARY OF COUNSELING

Complete this section during or immediately subsequent to counseling.

Key Points Discussion:

____ 1. This request for RC Managed Care cannot be processed if proper documentation is not provided by me.

____ 2. I must receive written authorization from TRICARE/MMSO BEFORE obtaining medical treatment from any civilian provider or I will be personally responsible for any charges incurred.

____ 3. I must report to all medical appointments including physical therapy and examinations. I understand I am not authorized to change, cancel, and/or reschedule my medical appointments. Failure to do so may result in termination of my active duty orders. First and second missed appointments will result in official counseling. A third missed appointment will result in an official reprimand and REFRAD.

____ 4. I must submit all medical treatment documentation, including the Physician's Statement, EACH MONTH to my Care Coordinator at the HIARNG Office of the State Surgeon (OTSS). Failure to do so may result in termination of my active duty orders.

____ 5. I must comply with all written or verbal physician's orders and understand failure to do so may result in termination of my active duty orders. I understand I cannot be on Convalescence Leave while on RCMC-M/T Orders.

____ 6. I understand while I am on 12301(h) orders, I will not perform a civilian job or Title 32 duties or missions. I understand I will not attend Military Residence Courses, civilian education classes or civilian education training during normal duty hours while on RC Managed Care orders.

____ 7. I have disclosed all medications, known medical diagnosis, and/or medical problems (treated/untreated) to the Case Manager and/or Care Coordinator prior to signing this form.

____ 8. I may be required to report to my unit of assignment or closest armory during a regular work week. I can only perform duties within the limitations of my profile (IAW AR 40-501, Ch 7) and must retain a copy of my profile with me at all times.

____ 9. If determined I have reached "Medical Retention Decision Point", I may be referred to the Physical Disability Evaluation System (PDES) process, which includes the Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB).

OTHER INSTRUCTIONS

This form will be destroyed upon: reassignment *(other than rehabilitative transfers)*, separation at ETS, or upon retirement. For separation requirements and notification of loss of benefits/consequences see local directives and AR 635-200.

____ 10. I understand I am participating in the RC Managed Care program on Title 10 orders and I am subject to UCMJ actions.
____ 11. I may have to repay any monies received if a later determination is made that I was not entitled to certain benefits.
____ 12. I will not engage in conduct prejudicial to the good order and discipline of my assigned duty site or unit.
____ 13. I will wear appropriate duty uniform as directed.
____ 14. I will maintain Army Physical Fitness Training regimen within the limitation of my profile in accordance with TC 3-22-20 (Army Physical Readiness Training) and maintain the height and weight standard in accordance with AR 600-9 (The Army Weight Control Program).
____ 15. I understand l must use any accrued leave during the dates of this approved Title 10 12301(h) Active Duty period.

Plan of Action *(Outlines actions that the subordinate will do after the counseling session to reach the agreed upon goal(s). The actions must be specific enough to modify or maintain the subordinate's behavior and include a specified time line for implementation and assessment (Part IV below).*

AS THE INDIVIDUAL MAKING THE CLAIM, I UNDERSTAND I AM RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED. I ALSO UNDERSTAND FAILURE TO FULFILL THE ABOVE REQUIREMENTS MAY RESULT IN TERMINATION OF MY ENTITLEMENTS TO PAY, ALLOWANCES, AND MEDICAL CARE FOR THIS DISABILITY. THE PENALTY FOR WILLFULLY MAKING A FALSE CLAIM IS A MAXIMUM FINE OF $10,000, IMPRISONMENT FOR FIVE (5) YEARS, OR BOTH.

Point of contact (POC) for this action is Rank/Name:

Unit:

Phone:

E-Mail

Session Closing: *(The leader summarizes the key points of the session and checks if the subordinate understands the plan of action. The subordinate agrees / disagrees and provides remarks if appropriate.)*

Individual counseled: ☐ I agree ☐ disagree with the information above.

Individual counseled remarks:

Signature of Individual Counseled:	DATE *(YYYYMMDD)*:

Leader Responsibilities: *(Leader's responsibilities in implementing the plan of action.)*

Signature of Counselor:	Date *(YYYYMMDD)*:

PART IV - ASSESSMENT OF THE PLAN OF ACTION

Assessment: *(Did the plan of action achieve the desired results? This section is completed by both the leader and the individual counseled and provides useful information for follow-up counseling.)*

Note: Both the counselor and the individual counseled should retain a record of the counseling.

SIGNATURES		
Counselor:	Individual Counseled:	Date of Assessment *(YYYYMMDD)*:

Note: Both the counselor and the individual counseled should retain a record of the counseling.