UNITED STATES MARINE CORPS
MARINE AIR GROUND TASK FORCE TRAINING COMMAND
MARINE CORPS AIR GROUND COMBAT CENTER
BOX 788100
TWENTYNINE PALMS, CALIFORNIA 92278-8100

1533
G-3
MAR - 6 2024

LETTER OF INSTRUCTION 5-24

From: Commanding General
To: Distribution List

Subj: DESERT HOT SPRINGS HIGH SCHOOL MARINE CORPS JUNIOR RESERVE OFFICERS TRAINING CORPS VISIT

Ref: (a) MCO 1533.6E
(b) CCO 3500.4M

Encl: (1) Desert Hot Springs High School JROTC Roster
(2) Visit Schedule - (MCAGCC)
(3) Informarion Consent and Waiver of Liability
(4) DD Form 2569

1. Situation. The Desert Hot Springs High School (DHSHS) Marine Corps Junior Reserve Officers Training Corps (MCJROTC) will visit the Marine Corps Air Ground Task Force Training Command (MAGTFTC), Marine Corps Air Ground Combat Center (MCAGCC) on 7 March 2024 in order to provide their cadets an orientation of the United States Marine Corps per chapter 5, paragraph 9 of reference (a).

2. Mission. Coordinate and support the DHSHS MCJROTC visit aboard MAGTFTC, MCAGCC on 7 March 2024.

3. Execution

a. Commander's Intent and Concept of Operations

(1) Commander's Intent. Provide the cadets with the opportunity to practice their marksmanship at the Marksmanship Training Unit (MTU), Indoor Simulated Marksmanship Trainer (ISMT). This event serves as an opportunity to build upon community relations by welcoming a group of young cadets, who are already inclined to consider a career in military service, and allow them the opportunity to learn and practice basic marksmanship fundamentals in a safe environment.

(2) Concept of Operations. The estimated attendance will be 33 cadets who range from ages 15 to 17 years old, and 1 adult staff member, see enclosure (1). A finalized roster will be submitted no later than two days prior to the visit. Enclosure (2) is the complete itinerary for the visiting group.

b. Subordinate Element Missions

(1) Assistant Chief of Staff (AC/S) G-3/5/7, Marine Air Ground Task Force Training Directorate

(a) Plan and coordinate the training.

(b) Schedule the required elements of the itinerary in accordance with enclosure (2).

(c) Provide cadet personnel rosters to G-4, Installation Support Directorate (ISD) and Mission Assurance (MA).

(d) Provide driver information to the Provost Marshal's Office.

(e) Collect the Hold Harmless Agreements from the MCJROTC unit; see enclosure (3).

(f) Reserve the MTU, ISMT and ensure proper instructor-staff support is available to support a shoot of simulated small-arms weapon systems.

(2) AC/S G-4, ISD

(a) Center Logistics Division. Coordinate with Littleton Dining Facility to provide the cadets the requested meal during the date and time required per the enclosure. Arrange for the appropriate tables to be set aside for the group.

(b) MA. Verify DHSHS, MCJROTC students against authorized access roster and provide vehicle access for 1 bus on 7 March 2024.

(c) Marine Corps Community Services. Notify the main base exchange that 33 cadets from DHSHS may access the exchange the afternoon of 7 March 2024.

c. Coordinating Instructions

(1) Safety

(a) In the event of an emergency situation or accident the DHSHS MCJROTC Escort Officer, Major Timothy Stefan, G-3, Assistant Operations Officer, will notify the MAGTFTC, MCAGCC Command Duty Officer in accordance with reference (b).

(b) The MCJROTC cadets may be treated at Robert E. Bush Naval Hospital, Twentynine Palms. Any medical services incurred will be billed to their non-Tricare insurance via enclosure (4).

(c) The MCJROTC unit must conduct Risk Management for all activities in accordance with reference (b).

(d) The training must be accomplished in strict compliance with established safety guidance. Cadets must have constant instructor supervision per reference (b).

(2) Transportation. The MCJROTC unit will use one bus to transport the cadets and staff throughout the Combat Center.

(3) Hold Harmless Agreements

(a) Non-Department of Defense civilians must sign the MAGTFTC,MCAGCC Hold Harmless Agreement prior to any training aboard the Combat Center; see enclosure (3).

(b) Each cadet's parents or legal guardians must sign the MAGTFTC, MCAGCC Hold Harmless Agreement prior to any training aboard the Combat Center utilizing enclosure (3).

4. Administration and Logistics. Directives issued by this Headquarters are published and distributed electronically. Electronic versions of Combat Center LOIs can be found at https://www.29palms.marines.mil/Staff-Offices/Resource-Management-Directorate/Adjutant/#combat-center-loi-library.

5. Command and Signal

a. Command

(1) The MAGTFTC,MCAGCC Action Officers for this event are Major Timothy Stefan at (760)830-1815 or timothy.stefan@usmc.mil and Staff Sergeant Cunningham at (760)830-1831 or sean.cunningham@usmc.mil.

(2) The senior DHSHS staff member is Master Sergeant Terrance Simmons, United States Marine Corps Retired, at work (760) 288-7102 and cell (951) 691-9686 or at tsimmons@psusd.us

(3) This LOI is applicable to active duty and civilian personnel participating in or supporting this event.

b. Signal. This LOI is effective the date signed.

S. A. GEHRIS
Chief of Staff

DISTRIBUTION: A

Desert Hot Springs High School

JROTC Roster

Adult Personnel

MSgt Terrance Simmons (Ret)

MCJROTC Cadets 15 Male 18 Females (33)

Jose De Jesus Sebastian

Samuel Sosa

Mauricio Hernandez

Deyo James

Angel Guevara

Braxton Parker

Mateo Salgado

Jonathan Ross

Axel Segura

Zane LaTray

Jesus Valdez

Roger Minjangos Ortega

Joseph Torres

Landon Posadas

Jose Lopez

Naomy Guevara

Ashley Morales

Emily Mira

Karol Posada Hernandez

Shaela Vazquez

Yulissa Lopez

Harmony Morin

Ayline Figueroa

Joselyn James

Jaquelyn Mejia

Sara Posada

Sofia Escobar Valladares

Andrea Balka

Julie Ruiz Mendoza

Lillie Rivera Mendoza

Camila Ursua

Katherine Corona

Maite Lopez Diaz

DESERT HOT SPRINGS HIGH SCHOOL MCJROTC VISIT

Visit Schedule – (MCAGCC)

Thursday – 7 March 2024

Time	Event	Location	Who	Support
0700	Depart DHSHS	Desert Hot Springs, CA	MCJROTC Cadets	Chartered Bus
0745	Arrive	Main Gate, MCAGCC	MCJROTC Cadets	PMO
0800 - 1100	Arrive	MTU ISMT	MCJROTC Cadets	AC/S G-3 MTU
1100	Depart MTU ISMT	MTU ISMT	MCJROTC Cadets	Chartered Bus
1130 - 1230	Lunch	Littleton Dining Facility	MCJROTC Cadets	AC/S G-4 ISD
1230	Depart	Littleton Dining Facility	MCJROTC Cadets	Chartered Bus
1300 - 1430	MCX Visit	Main Exchange	MCJROTC Cadets	AC/S G-4 ISD
1430	Depart	Main Exchange	MCJROTC Cadets	Charted Bus
1530	Arrive DHSHS	Desert Hot Springs, CA	MCJROTC Cadets	Chartered Bus

INFORMATION CONSENT AND WAIVER OF LIABILITY

Assumption of Risk

This is a voluntary release of liability and complete assumption of risk. I, (print name) _____, hereby release Marine Corps Air Ground Combat Center Twentynine Palms (hereinafter "Twentynine Palms"), the United States Marine Corps, the Department of the Navy, the United States Government, and all agencies and instrumentalities thereof, its agents, officers, servants, and personnel (hereinafter "the government"), from any and all liability, claims, demands and actions whatsoever resulting from my presence on Twentynine Palms, or my involvement in activities aboard Twentynine Palms.

This release applies to myself, and to my parents, spouse, children, guardian, executors, future heirs, assigns, creditors and administrators. This release of liability includes, but is not limited to claims based on negligence, both passive and active, of the government arising out of, or relating to any loss, damage (including loss of and damage to property), illness, death, or injury that may be sustained while on Twentynine Palms. This release also applies to all dangers inherently involved in the activities in which I desire to participate. I understand that the risks involved in these activities include, but are not limited to, risks resulting from firearms, projectiles, other equipment, terrain, my personal physical condition, vehicles, other participants and lack of hydration. I am entering Twentynine Palms to utilize training areas normally designated for military activities.

Other known risks aboard military installations include, but not limited to: (1) Inquiries or death resulting from strenuous activities; (2) Injuries or death resulting from recreational activities; (3) High volumes of traffic by civilian and military vehicles; (4) Interactions with animals, both wild and domestic; (5) Significant distances from recreational areas to medical treatment facilities or hospitals; and (6) Potentially hazardous training activities, including but not limited to, range firing, aircraft operations, and field maneuvers; (7) Hazards inherent to military facilities, including but not limited to, being wounded by errant projectiles, being injured by target apparatus, and exploding ammunition or weapons.

I hereby authorize emergency medical treatment in the event of injury or illness. I also authorize trained health care providers, including, but not limited to physicians, nurses, nurse practitioners, emergency medical technicians and hospital corpsmen, to administer routine and/or emergency medicine and treatments, as needed.

This release shall remain in effect, indefinitely, from the date of signature until rescinded in formal writing by the government.

I further state that I, (print name) _____, have carefully read the foregoing release, know the contents thereof, and sign this release as my own free act, on behalf of myself and/or my child or children for whom I am authorized to act as legal guardian.

_____ _____

Date Signature of Releaser

Phone Number: _____

Witness: _____

Witness: _____

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2569.pdf

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires October 31, 2023

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079b, Procedures for charging fees for care provided to civilians; retention and use of fees collected; 10 U.S.C. 1095, Health care services incurred on behalf of covered beneficiaries: Collection from third-party payers; 42 U.S.C. Chapter 32, Third Party Liability For Hospital and Medical Care; and E.O. 9397 (SSN), as amended.
PURPOSE: DD Form 2569 collects individual's information to assist the Department of Defense ("DoD") in its recovery from third parties for medical care provided to an individual in a Military Treatment Facility.
ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to commercial insurance carriers and third parties involved in support of DoD's collection activities for health care provided; to the Departments of Treasury, Veterans Affairs, and Homeland Security for reimbursement of DoD provided medical services; to other persons or organizations who may be liable for payment of DoD provided health care and medical services; to data clearinghouses and insurance carriers related to converting medical and pharmacy claims to an industry-wide format related to payment of claims. For additional details as to routine uses and exceptions to the DoD Blanket Routine Uses, see the below hyperlinked SORN.
APPLICABLE SORN: EDHA 12, Third Party Collection System (July 15, 2016; 81 FR 46069)
https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570677/edha-12/
DISCLOSURE: Voluntary. If you choose not to provide the requested information, no penalties will be imposed; however, failure to provide complete and accurate information may result in disqualification for health care services.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	**2. SSN**	**3. DATE OF BIRTH** *(YYYY/MM/DD)*

4a. MAILING ADDRESS *(Include ZIP Code)*	b. HOME TELEPHONE NO. ( )	
	5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

☐ a. **YES.** *(If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)*

(1) Member ID	(2) Plan ID	(3) Expiration Date *(YYYY/MM/DD)*

(4) VA Facility Name *(e.g., primary care/specialty clinic)* that assists in coordinating your care

(5) VA Facility Address and Telephone Number

( )

☐ b. **NO.** *(Proceed to Item 8.)*

8. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)* **PLEASE ATTACH COPY OF INSURANCE CARD** *(If available)*.

☐ a. **YES.** *(Complete Item 9 and the remaining sections below.)*
☐ b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 13.)*
☐ c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 12.)*

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. MEMBER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME

j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. MEMBER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	**k. INSURANCE TYPE**	**l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)***	**m. POLICY END DATE *(YYYY/MM/DD)***

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number		
(2) Rx Policy ID	**(3) Rx Bin Number**	**(4) Rx PCN Number**

11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** *(Complete 11c.-f. and proceed to Item 13.)* ☐ b. **NO** *(Proceed to Item 13.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

12. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE ID NUMBER	b. MEDICARE MANAGED CARE PLAN NAME
c. MEDICARE PART D NUMBER AND PLAN NAME	**d. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING**

13. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.

e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYY/MM/DD)*

16. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

17a. SIGNATURE *(Patient or Adult Family Member)*	b. DATE *(YYYY/MM/DD)*

18. VERIFICATION a. (1) Date *(YYYY/MM/DD)*	(2) Initials	b.(1) Date *(YYYY/MM/DD)*	(2) Initials	c.(1) Date *(YYYY/MM/DD)*	(2) Initials