GENETICALLY HANDICAPPED PERSONS PROGRAM ENROLLMENT FEE APPEAL

To appeal the Genetically Handicapped Persons Program (GHPP) enrollment fee, complete this form and send by fax (916) 440-5318, email GHPPEligibility@dhcs.ca.gov, or mail to: GHPP MS 4507, P.O. Box 997413 Sacramento, CA 95899-7413, along with any additional required supporting documentation. Program staff will review and contact the individual regarding the appeal determination. All required fields must be completed, and required supporting documentation must be received by GHPP for an appeal to be considered.

Client Personal Information

Last Name:	First Name:	Middle Initial:	Date of Birth:
GHPP Case Number (if known)	Phone Number:	Email Address:	

Complete the appropriate fields below as they apply to your current financial situation.

☐ I have a substantial change in the family gross income stated in my recent GHPP application.
Date the change occurred:
The reason my income changed:
☐ If reason for income change is loss of employment, I have provided dated proof of job termination or a signed statement declaring unemployment that has been notarized by a notary public.
Current annual family gross income is now:

☐ I have been granted disability, and have included a copy of my disability statement.
Name of the organization granting your disability:
Disability is: ◯permanent ◯not permanent
Disability monthly amount:

☐ I am receiving Social Security Income (SSI), and included a copy of my most recent SSI statement and/or award letter.
Monthly amount received:

☐ I have been approved for the Medi-Cal program, and included a copy of the Notice of Action (NOA) from the Department of Social Services, Medi-Cal Eligibility Office.

☐ I have no personal income from any source and am completely supported by family or friends. I have included a signed statement to this effect that has been notarized by a notary public.

☐ My doctor recommends I stop working due to medical reasons, and I have included a signed and dated letter from my doctor.

☐ I have unavoidable family expenses that I wish the program to consider for an enrollment fee reduction or waiver. I have listed on page two of this form each of these expenses, and attached at least one copy of a receipt, statement or invoice verifying the amount of each expense claimed.

Examples of acceptable expenses:	Examples of unacceptable expenses:
• Utility bills (water, gas, electric, etc) • Phone and internet • Travel expenses for work • Insurance for primary vehicle • Large, one-time medical expenses • Tuition for immediate family members • Large, one-time emergency expenses (please describe) • Rent/Mortgage for primary residence • Groceries not exceeding $500 monthly (provide receipts or statement)	• Cable, streaming, and other “entertainment” bills • Credit card bills or other debts • Insurance for secondary vehicles • Monthly medical insurance premiums (including GHPP fees) • Maintenance of luxury items (pool, timeshare, secondary properties, etc) • Gifts to friends or family • Travel expenses unrelated to work

Complete this page only if you checked the box on page one claiming you have unavoidable family expenses you wish to submit for reconsideration of your enrollment fee amount. If so, please list below each expense to be considered. Copies of each proof of expense must be included. Payment(s) for expenses must have been made within one year of the receipt of this appeal.

Item # (indicate # on copy of attached proof of expense	Description of expense:	Monthly amount (if recurring expense):	One-Time Amount:	Proof type of expense (Invoice, Bank Statement, Receipt, etc.)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

Total monthly expense amount:

By signing below I certify that the information I have given on this form is true and correct to the best of my knowledge.

Signature of GHPP client or parent/legal guardian of minor/child:	Date:

Privacy Notice on Collection

This privacy notice is required by California Civil Code section 1798.17. The purpose of this form is to allow Genetically Handicapped Persons Program (GHPP) clients to appeal an enrollment fee. The personal and/or medical information collected in this form is by request of the Department of Health Care Services' GHPP Program, Clinical Assurance Division, and is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Parts 160, 164), the Information Practices Act (California Civ. Code, § 1798 et seq.), Department of Health Care Services (Department) policy, and state policy. The information in this form is being collected by the Department's Clinical Assurance Division by the authority of Health & Safety Code Sections 125155, 125155.1, 125157, 125166, 125175, 125180, & 125185.

All information requested in this form is required unless otherwise stated. If you do not provide the required information, the Department will return your application form to you as incomplete. The Department may share provided information with: (1) other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected, (2) local, state, or federal government entities if required by state or federal law, and (3) health plans. Please do not provide any personal or medical information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. The Department may charge a small fee to cover the cost of duplicating this information. For more information or access to records containing your personal information maintained by the Department, contact the following:

Office Technician
DHCS/CADPO Box 997419
Sacramento, CA. 95899
Telephone: (916) 552-9100

If you wish to obtain a paper copy of DHCS' privacy policy and practices, or wish to file a complaint regarding privacy practices, you may contact the Department's Data Privacy Unit by mail, email, or telephone:

Privacy Office
c/o: Data Privacy Unit
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: incidents@dhcs.ca.gov
Telephone: (916) 445-4646

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).