GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
APPLICATION TO DETERMINE ELIGIBILITY

Refer to the Instructions on Page 4, 5 and 6 When Filling in this Application

Please provide all the information requested and return this form to the GHPP. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE.

If you have any questions about completing this form, email the GHPP at GHPPEligibility@dhcs.ca.gov or call 1 (916) 552-9105 or toll free at 1 (800) 639-0597.

Section A: Personal Information

1. Name (Last) (First) (MI)	2. Other Name(s) Used	3. Social Security Number (Optional)

4. Address	City	County	Zip Code
4(a). Mailing Address (if different)	City	County	Zip Code

5. Day Telephone	6. Email Address	7. Mother's First and Maiden Name	8. Language

9. Date of Birth	10. Place of Birth: County, State, Country	11. Gender

12. What is your GHPP Eligible Condition?

13. Race/Ethnicity

14. Name of the Physician who Treats your GHPP Eligible Condition. Include NPI Number if known.

14(a). Treating Physician's Address

14(b) Physician's Contact Phone Number

15. Name of your Special Care Center Facility

16. Name of Primary Care Physician (PCP)

16(a). PCP's Address

16(b) PCP's Contact Phone Number

17. Power of Attorney / Conservator Information (If Applicable)

YOU MUST ATTACH SUPPORTING DOCUMENTATION

Name:

Title:

Address:

Telephone Number:

Section B: Health Insurance Information

18. Do you have Medi-Cal? Yes ◯ No ◯
a. If Yes, what is your Beneficiary I.D. Card (BIC) number? _____

19. Do you have Medicare? Yes ◯ No ◯ If yes, what is your Medicare number? _____
19b. Please check all Medicare Programs you are enrolled: Part A ☐ Part B ☐ Part C ☐ Part D ☐

20. Do you have Other Health Insurance? Yes ◯ No ◯

a. If Yes: Through your Employer ☐ Through Family Member ☐ Through Retirement Benefits ☐

Insurance Company: _____

b. Type of Plan: ☐ Preferred Provider Organization (PPO) ☐ Health Maintenance Organization (HMO)
Other (Specify): _____

c. Policy Number _____ Coverage Start Date: _____

d. Who pays for the policy? Employer ☐ Self ☐ Employer and Self ☐

Other (Specify) _____

When Cost-Effective, the Health Insurance Premium Reimbursement (HIPR)

Program may Reimburse for the cost of your Third-Party Health Coverage.

e. Are you Currently Participating in the HIPR Program? Yes ◯ No ◯

i. If yes, would you like the HIPR program to Continue Reimbursing you? Yes ◯ No ◯

ii. If no, would you like Reimbursement for your Third-Party Health Coverage Premiums? Yes ◯ No ◯

f. Has any of your Insurance Information Changed Since the Last Filing? Yes ◯ No ◯

i. If yes, explain why: _____

Please Attach a copy of the Insurance Card. To Continue your Participation in the HIPR, Submit your GHPP Renewal Application Annually

g. If your employer provides health insurance and you choose not to participate in your employer's plan, state why below:

☐ The Premium is too Expensive
☐ I lost my job, am eligible to continue my coverage under COBRA, and can not afford to pay the insurance premium.
☐ I have met the lifetime coverage limit of my employer's health insurance coverage.
☐ The physician providing care for my condition is not part of the plan's provider network.
☐ Other (please specify) _____

Section B: Health Insurance Information

h. During the last six months from the date of this application, has either your employer or yourself terminated your employer's sponsored health insurance? Yes ◯ No ◯

If yes, what date was it terminated? _____

Please state why below:

- ☐ Change in employment status, including loss of employment.
- ☐ Your employer discontinued health benefits to all employees and/or dependents.
- ☐ A change of your address to a ZIP Code that is not covered by your employer's health insurance.
- ☐ Death of, or legal separation/divorce of, the individual through whom the health insurance was provided.
- ☐ You have met the lifetime coverage limit of the employer's health insurance.
- ☐ Coverage was under a COBRA policy and the COBRA coverage period has ended.
- ☐ Other (please specify) _____

21. Do You Have:

a. Dental Insurance Yes ◯ No ◯ If yes, name of plan: _____

b. Vision Insurance Yes ◯ No ◯ If yes, name of plan: _____

Section C: Certification

(Initial and Sign Below. Your Signature Authorizes GHPP to Proceed with Your Application.)

Read and Initial Each Statement Below:

____ I am applying to the GHPP in order to determine my eligibility for services/benefits. I understand that the completion of this application does not guarantee my acceptance into the GHPP.

____ I give my permission for the GHPP to verify my residence, health information, income and/or other circumstances which may be required to determine my GHPP eligibility and enrollment fee amount (if any).

____ I give permission for the GHPP to leave messages concerning my GHPP participation on my designated telephone answering machine/service.

____ I certify that I have read this information, or had it read to me, and that I understand it.

____ I certify that the information I have given on this form is true and correct to the best of my knowledge

Signature of GHPP Applicant or Parent/Legal Guardian of Minor/Child:	Relationship to Minor Child:	Date:

If Signing with an "X", Signature of Witness:	Relationship of Witness to GHPP Applicant:	Witness Phone Number:	Date:

California law requires that families applying for services be given information on how GHPP protects their privacy.[1] To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP via email to GHPPEligibility@dhcs.ca.gov, or call 1 (916) 552-9105 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

1) Civil Code, Section 1798.17
2) In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3) Section 123800 et. seq. of the California Health and Safety Code

Application to Determine GHPP Program Eligiblity

Sexual orientation and gender identity questions for the implementation of Assembly Bill 959, Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act.

Assembly Bill 959 (an act to add Section 8310.8 to the Government Code, relating to data collection, Chapter 565, 2015), Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act requires the Department of Health Care Services to collect voluntary information about applicants' sexual orientation and gender identity. Please fill in below to tell us more about the applicant's gender, gender identity, gender expression or sexual orientation

What was your sex assigned at birth? (required)

- [ ] Female
- [ ] Male
- [ ] Intersex

What is your gender identity (optional)
(check the box the best describes your current gender identity)

- [ ] Female
- [ ] Male
- [ ] Transgender: Male to female
- [ ] Transgender: Female to male
- [ ] Non-Binary
- [ ] Another gender identity

What sex is listed on your original birth certificate? (optional)

- [ ] Female
- [ ] Male

Do you think of yourself as? (optional)

- [ ] Straight or heterosexual
- [ ] Gay or lesbian
- [ ] Bisexual
- [ ] Queer
- [ ] Another Sexual orientation
- [ ] Unknown

INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) APPLICATION
TO DETERMINE ELIGIBILTY

Please print clearly so your application can be processed as quickly as possible.

Fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 552-9105 or toll free at 1 (800) 639-0597. Once the application is completed, email it to the GHPP inbox GHPPEligibility@dhcs.ca.gov, or mail the application to Genetically Handicapped Persons Program MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name:** Write your last name, first name, and middle initial. **Attach proof of identity, such as a copy of your California driver's license or California identification card to the application.**
2. **Other name(s) used:** If you are legally known by any other name, write in the name(s).
3. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.
4. **Address:** Write your residence street number, street name, apartment number, city, county, and zip **code. Do not use a P.O. Box in this space. Attach a copy of one of the following to show proof of residency in California. If you do not have one of the following items, please call the GHPP to discuss additional acceptable items.**

• Current California utility bill • Rent or mortgage receipt • Document showing employment in California	• Evidence of registering to vote in California • Evidence of enrollment in a California school • Evidence of receiving California public assistance

4a. Mailing address: Write your mailing address, a P.O. Box is acceptable.

5. Day telephone number: Write the telephone number where you can be reached during the day including area code.

6. Email Address: Write the email address where the applicant can be reached.

7. Mother's first and last (maiden) name: Write your mother's first name and last (maiden) name.

8. Primary language: Write the name of the language in which you are most comfortable communicating.

9. Date of birth: Write the month, day, and year of your birth.

10. Place of birth: Write the county and state in which you were born. Write the country if you were born outside of the United States.

11. Gender: Fill in the applicant's gender (male or female) or see page 4 to provide more information about the applicant's gender, gender identity, gender expression or sexual orientation.

**INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS
PROGRAM (GHPP) APPLICATION TO DETERMINE
ELIGIBILTY**

12. What is your GHPP eligible condition? Write the condition which qualifies you for the **GHPP. The following is a list of GHPP-eligible conditions:**

- Cystic Fibrosis
- Friedreich's Ataxia
- Hemophilla Factor Deficiency (please specify factor type)
- Huntington's Disease
- Joseph's Disease
- Sickle Cell Disease
- Thalassemia Major
- Thrombasthenia
- Thrombocytopathia
- Von Hippel-Lindau
- Von Willebrand's Disease
- Metabolic Disease (e.g., PKU, Tyrosinemia, branch chain amino acid, Maple Syrup Urine Disease, urea cycle disorders, Wilson's Disease)
- Other metabolic disease (please specify)

13. Race/ethnicity: Write the category from the following list which best describes your primary **race/ethnicity.**

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African-American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

14. Name of the Physician Who Treats your GHPP Eligible Condition: Write the name of the **physician who treats your GHPP eligible condition.**

14a. Treating Physician's address: Write the physician's street number, street name, city, county, **and zip code that treats your GHPP eligible condition.**

14b. Treating Physician's telephone number. Write the physician's telephone number, including **the area code that treats**

15. Name of your Special Care Center Facility. Write the name of your Special Care Center, if you have one.

16. Name of Primary Care Physician (PCP). Write the name of the primary care physician who may or may not treat your GHPP Eligible condition.

16a. PCP Address. Write the address of your Primary Care Physician.

16b. PCP Contact Phone Number. Write the phone number of your Primary Care Physician.

INSTRUCTIONS FOR COMPLETING THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) APPLICATION TO DETERMINE ELIGIBILTY

Section B: Health Insurance Information: The GHPP is considered the payer of last resort. In other words, the GHPP will pay for your medically necessary health care only after any other health coverage you may have has paid.

17. **Power of Attorney/Conservator information:** If you have legally appointed someone to act as your Power of Attorney for health care, or if a conservator has been appointed for you, please write the name, title (i.e. Power of Attorney, Conservator), address, and telephone number for this individual. **You MUST attach documentation of this person's legal authority to act on your behalf if you wish for them to be able to communicate with the GHPP regarding your health care.**

18. **Do you have Medi-Cal?** Check the correct response (Yes or No).
    a. **If yes, what is your Beneficiary I.D. Card (BIC) number?** Write your Medi-Cal BIC I.D. number.

19. **Do you have Medicare?** Check the correct response (Yes or No).
    a. **If yes, what is your Medicare number?** Write your Medicare I.D.
    b. **Please check all Medicare programs in which you are enrolled:** Check all that apply (Parts A, B, C, D).

20. **Do you have other health insurance?** Check the correct response (Yes or No).
    a. **If yes,** Check the response which matches who your insurance is through and write the full name of your insurance company (i.e. Kaiser Permanente, Blue Cross of California, etc.).
    b. **Type of plan:** Check the response which matches the type of plan you have. NOTE: If you have an HMO, PPO or POS, please send a copy of your benefit booklet with your GHPP application.
    c. **Policy number/Coverage start date:** Write your health insurance policy number and the start date of your coverage.
    d. **Who pays for the policy?** Check the response which applies to your policy. If you check "Other" please specify who pays (i.e. Family).
    e. **When cost-effective, the HIPR Program may reimburse you for the cost of your third-party health coverage. Are you currently participating in the HIPR Program?** Check the correct response (Yes or No). **If yes, would you like the HIPR Program to continue reimbursing you?** Check the correct response (Yes or No) **If no, would you like reimbursement for your third-party health coverage premiums?** Check the correct response (Yes or No).
    f. **Has any of your insurance information changed?** If yes, please explain why.
    g. **If your employer provides health insurance and you choose not to participate in your employer's plan:** Check the response that explains why you choose not to participate. If you check "Other" please explain.

**INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS
PROGRAM (GHPP) APPLICATION TO DETERMINE
ELIGIBILTY**

h. During the last six months from the date of this application, has either your employer or yourself terminated your employer's sponsored health insurance? Check the correct response. If yes, include the date the insurance was terminated and the reason why it was terminated. If you check "Other" please explain.

21. Do you have

a. Dental Insurance? Check the correct response (Yes or No). If Yes, write the name of the plan.

b. Vision insurance? Check correct response (Yes or No). If Yes, write the name of the plan.

Section C: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink, in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Email the application to GHPPEligibility@dhcs.ca.gov, or mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413.

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION

Refer to the Instructions on Page 6 through 9 When Filling in this Application

The following information is required by the GHPP to determine your enrollment fee amount, if any. Your enrollment fee is based upon your family gross income for the previous year. Your income information is reviewed annually, and therefore your enrollment fee may change from year to year.

Section A: Personal Information

1. Name (Last)	(First)	(MI)	2. Social Security Number
_____	_____	____	_____

3. Address (number, street, apartment #)	City	County	Zip Code
_____	_____	_____	_____

4. Telephone Number (Include Area Code)	5. Email Address
_____	_____

Section B: Income Verification

6. Family Gross Income
$ _____

7. List Income Data Source(s) and Attach

Copies

_____ _____

_____ _____

_____ _____

8. Family Size _____

List Family Members, Including Yourself, Who Are Dependent on the Family Income

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

(Use additional paper if more space is needed)

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION
Refer to the Instructions on Page 3 and 4 When Filling in this Application

9. Employment Information

Your Employer's Name _____

Employer's Telephone Number _____

Employer's Address _____

Section C: Enrollment Fee Information

NOTIFICATION OF ENROLLMENT FEE STATUS:

a. When the GHPP has calculated the amount of your enrollment fee, you will be sent a written notification. The total enrollment fee will be provided on an Enrollment Fee Agreement. The Enrollment Fee Agreement will specify the amount owed and two options for payment:

   i. One lump sum due no later than the 60th day from the date of notification from the GHPP, or

   ii. Two or three payments which are due no later than the 60th, 120th, and 180th days from the date of notification from the GHPP.

b. FAILURE TO PAY THE ENROLLMENT FEE ACCORDING TO THE SIGNED AGREEMENT WILL RESULT IN CLOSURE OF YOUR CASE ON THE 61ST, 121ST, OR 181ST DAY FROM THE DATE OF NOTIFICATION FROM THE GHPP.

Section D: Certification

Read and Initial Each Statement Below:

_____ I understand that my enrollment fee, if any, will be based on my stated income and that my enrollment fee may change annually if my income changes.

_____ I give my permission for the GHPP to verify my income and/or other circumstances which may be required to determine my annual enrollment fee, if any.

_____ I certify that I have read this information, or had it read to me, and that I understand it.

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

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION

Refer to the Instructions on Page 3 and 4 When Filling in This Application

Section D: Certification

Read and Initial Each Statement Below:

_____ I understand that my enrollment fee, if any, will be based on my stated income and that my enrollment fee may change annually if my income changes.

_____I give my permission for the GHPP to verify my income and/or other circumstances which may be required to determine my annual enrollment fee, if any.

_____I certify that I have read this information, or had it read to me, and that I understand it.

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

Signature of GHPP Applicant/Client or Parent/ Legal Guardian of minor / child:	Relationship to Minor / Child:	Date:
_____	_____	_____

If Signing with an "X," Signature of Witness:	Relationship of Witness to GHPP Applicant/Client:	Witness Telephone Number:	Date:
_____ Print name _____	_____	_____	_____

California law requires that families applying for services be given information on

how GHPP protects their privacy. [1] To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP at 1 (916) 552-9105 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

INSTRUCTIONS FOR COMPLETING THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) INITIAL/ ANNUAL INCOME VERIFICATION FORM

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 552-9105 or toll free at 1 (800) 639-0597. Once the application is completed, email it to the GHPP inbox GHPPEligibility@dhcs.ca.gov, or mail the application to GHPP MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name:** Write your last name, first name, and middle initial.

2. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.

3. **Address:** Write your residence street number, street name, apartment number, city, county, and zip code. Do not use a P.O. Box.

4. **Telephone Number:** Write the telephone number where you can be reached, including the area code.

5. **Email:** Write the email address where you can be reached.

Section B: Income Verification: Follow the instructions for each number below. Your enrollment fee, if any, will be based upon the information you provide.

6. **Family Gross Income:** This is information found on your tax forms 1040 and 540. You can also use your forms W-2 and/or other documents listed below in Item 7. You must include income from members of your family who are dependent on the family income. Use the income amount from the previous year. Examples:

   - If you are not claimed on anyone else's tax returns and you earn your own income, this is the amount you must report.
   - If you are married you must report both your income and the income of your spouse, even if you file separately.
   - If you live with a family member who claims you on their tax returns, you must use their income amount and supply copies of their tax returns.
   - YOU DO NOT have to include the income from members of your household such as roommates or siblings.

If you have questions about what income you must report, please contact the GHPP.

INSTRUCTIONS FOR COMPLETING THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) INITIAL/ ANNUAL INCOME VERIFICATION FORM

7. **List income data source(s) and attach copies:** This means the document(s) you used to calculate the amount listed in Item 6. Attach a copy of your **Federal Tax Form 1040** and any of the following documents used to calculate your family gross income.

- Social Security income statement
- Disability income statement
- Forms W-2
- Pay stubs
- Other (please specify)

8. **Family size:** List members of your household who are dependent on the family income. Your family size is considered when calculating your enrollment fee. Attach an additional sheet if more space is needed.

9. **Employment information:** List your employer's name, telephone number, and address.

Section C: Enrollment Fee Information: Read this important information about your enrollment fee.

Section D: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Email the completed form to GHPPEligibility@dhcs.ca.gov, or mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413.

1) Civil Code, Section 1798.17
2) In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3) Section 123800 et. seq. of the California Health and Safety Code