

**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,  
call the GHPP at 1 (916) 327-0470 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 (Number, Street, Apartment Number)		City		County Zip Code	
4(a). Mailing Address (if different from above)		City		County Zip Code	
5. Day Telephone Number	6. Evening Telephone Number	7. Mother's First and Last (Maiden) Name		8. Primary Language	
9. Date of Birth (mm/dd/yyyy)	10. Place of Birth	County:	State:	Country:	11. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
12. What is Your GHPP Eligible Condition?					
13. Race/Ethnicity					
14. Name of Your Physician Who Treats Your GHPP Eligible Condition?			15. Name of your Special Care Center Facility		
14(a). Treating Physician's Address					
14(b). Treating Physician's Phone Number ( )					
16. Power of Attorney/Conservator Information (If Applicable)					
<b>YOU MUST ATTACH SUPPORTING DOCUMENTATION</b>					
Name: _____			Title: _____		
Address: _____			Telephone Number: _____		

**Section B: Health Insurance Information**

17. Do You Have Medi-Cal? Yes  No   
 a. If Yes, What is Your Beneficiary I.D. Card (BIC) Number? \_\_\_\_\_

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18. Do You Have Medicare? Yes  No  a. If Yes, What is Your Medicare Number? \_\_\_\_\_  
 b. Please Check All Medicare Programs in which You are Enrolled: Part A  Part B  Part C  Part D

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19. Do You Have Other Health Insurance? Yes  No   
 a. If Yes, Through your Employer  Through a Family Member  Through retirement Benefits   
 Name of Insurance Company: \_\_\_\_\_  
 b. Type of plan: Preferred Provider (PPO)  Health Maintenance Organization (HMO)  Other (Specify) \_\_\_\_\_  
 c. Policy Number \_\_\_\_\_ Coverage Start Date: \_\_\_\_\_  
 d. Who Pays for the Policy? Employer  Self  Employer and Self  State of California HIPR Program   
 Other (Specify) \_\_\_\_\_  
 e. When cost-effective, the Health Insurance Premium Reimbursement (HIPR) Program may reimburse for the cost of your third-party health coverage. Are you currently participating in the HIPR Program? Yes  No   
 If yes, would you like the State of California HIPR Program to continue reimbursing you? Yes  No   
 If no, would you like reimbursement for your third-party health coverage premiums? Yes  No   
 f. Has any of your insurance information changed? Yes  No   
 If yes, please explain why:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 g. If your employer provides health insurance and you choose not to participate in your employer's plan, state why by choosing one of the following:  
 The premium is too expensive.  
 I lost my job and am eligible to continue my coverage under COBRA and can not afford to pay the insurance premium.  
 The employer's health insurance coverage is not available because I have met the lifetime coverage limit.  
 The physician providing care for my condition is not part of the plan's provider network.  
 Other (please specify) \_\_\_\_\_  
 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 by choosing one of the following:  
 Loss of employment or a change in employment status.  
 Your employer discontinued health benefits to all employees or dependents.  
 A change of 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.  
 The employer's health insurance coverage became unavailable because you have met the lifetime coverage limit.  
 Coverage was under a COBRA policy and the COBRA coverage period has ended.  
 Other (please specify) \_\_\_\_\_

20. Do You Have: a. Dental Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name of Plan: _____  b. Vision Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name of Plan: _____
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**Section C: Certification**

**(Initial and Sign Below. Your Signature Authorizes the 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.<sup>1</sup>  
To protect your privacy:

- GHPP must keep this information confidential.<sup>2</sup>
- 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) 327-0470 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.<sup>3</sup>

<sup>1</sup> Civil Code, Section 1798.17

<sup>2</sup> In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)

<sup>3</sup> Section 123800 et. seq. of the California Health and Safety Code

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

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) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, mail it to the GHPP. **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.**
2. **Other name(s) used:** If you are legally known by any other name, write in the name.
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.

<ul style="list-style-type: none"> <li>• Current California utility bill</li> <li>• Rent or mortgage receipt</li> <li>• Document showing employment in California</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of registering to vote in California</li> <li>• Evidence of enrollment in a California school</li> <li>• Evidence of receiving California public assistance</li> </ul>
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- 4a. **Mailing address:** Write your mailing address. If you prefer to receive your mail at a P.O. Box, write in this space.
5. **Day telephone number:** Write the telephone number where you can be reached during the day including area code.
6. **Evening telephone number:** Write the telephone number where you can be reached in the evening including area code.
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:** Please check the correct gender (male or female).
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:

<ul style="list-style-type: none"> <li>• Cystic Fibrosis</li> <li>• Friedreich’s Ataxia</li> <li>• Hemophilla Factor Deficiency (please specify factor type)</li> <li>• Huntington’s Disease</li> <li>• Joseph’s Disease</li> <li>• Sickle Cell Disease</li> <li>• Thalassemia Major</li> <li>• Thrombasthenia</li> </ul>	<ul style="list-style-type: none"> <li>• Thrombocytopenia</li> <li>• Von Hippel-Lindau</li> <li>• Von Willebrand’s Disease</li> <li>• Metabolic Disease (e.g., PKU, Tyrosinemia, branch chain amino acid, Maple Syrup Urine Disease, urea cycle disorders, Wilson’s Disease)</li> <li>• Other metabolic disease (please specify)</li> </ul>
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**13. Race/ethnicity:** Write the category from the following list which best describes your primary race/ethnicity.

<ul style="list-style-type: none"> <li>• Alaskan Native</li> <li>• Amerasian</li> <li>• American Indian</li> <li>• Asian</li> <li>• Asian Indian</li> <li>• Black/African-American</li> <li>• Cambodian</li> <li>• Chinese</li> <li>• Filipino</li> <li>• Guamanian</li> </ul>	<ul style="list-style-type: none"> <li>• Hawaiian</li> <li>• Hispanic/Latino</li> <li>• Japanese</li> <li>• Korean</li> <li>• Laotian</li> <li>• Samoan</li> <li>• Vietnamese</li> <li>• White</li> <li>• Other</li> </ul>
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**14. Name of your Physician Who Treats your GHPP Eligible Condition:** Write the name of your physician who treats your GHPP eligible condition.

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

**14b. Treating Physician’s telephone number.** Write your physician’s telephone number, including the area code that treats your GHPP eligible condition.

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

**16. 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.**

**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. 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 BIC I.D. number.

**18. 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).

**19. 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.

- 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.

**20. 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:** Mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413.

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

Refer to the Instructions on Page 3 and 4 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.**

<b>Section A: Personal Information</b>			
1. Name (Last) _____ (First) _____ (MI) _____		2. Social Security Number (Optional) _____	
3. Address (number, street, apartment #) _____		City _____	County _____
		Zip Code _____	
4. Daytime Telephone Number (include area code) _____		5. Evening Telephone Number (include area code) _____	
<b>Section B: Income Verification</b>			
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)			
9. Employment Information			
Your Employer's Name _____			
Employer's Telephone Number _____			
Employer's Address _____			
<b>Section C: Enrollment Fee Information</b>			
<b>NOTIFICATION OF ENROLLMENT FEE STATUS:</b>			
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 60 <sup>th</sup> day from the date of notification from the GHPP, <u>or</u>			
ii. Two or three payments which are due no later than the 60 <sup>th</sup> , 120 <sup>th</sup> , and 180 <sup>th</sup> days from the date of notification from the GHPP.			
b. <b>FAILURE TO PAY THE ENROLLMENT FEE ACCORDING TO THE SIGNED AGREEMENT WILL RESULT IN CLOSURE OF YOUR CASE ON THE 61<sup>ST</sup>, 121<sup>ST</sup>, OR 181<sup>ST</sup> DAY FROM THE DATE OF NOTIFICATION FROM THE GHPP.</b>			

**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. <sup>1</sup>

To protect your privacy:

- GHPP must keep this information confidential.<sup>2</sup>
- 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) 327-0470 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.<sup>3</sup>

**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) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, mail it to the GHPP. **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. **Daytime telephone number:** Write the telephone number where you can be reached during the day including the area code.
5. **Evening telephone number:** Write the telephone number where you can be reached in the evening including the area code.

**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.

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.

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

**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:** Mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, 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