Genetically Handicapped Persons Program Application to Determine Eligibility

Refer to the instructions on pages 5, 6, 7, and 8 when completing this form. Please provide all the information requested and return this form to the Genetically Handicapped Persons Program (GHPP). Please type or print. Do not abbreviate. If you have any questions about completing this form, email GHPP at GHPPEligibility@dhcs.ca.gov or call (916) 713-8400.

Section A: Personal Information				
1a. Last Name:	1b. First Name:			1c. MI:
2. Other Name(s) Used:			3. Social Security Number (optional):	
4a. Residential Address:	4b. City:		4c. County:	4d. Zip Code:
5a. Mailing Address (if different):	5b. City:		5c. County:	5d. Zip Code:
6. Phone Number:	7. Email Address:	8. Mother's First and Maiden Name:		9. Language
10. Date of Birth:	11a. County of Birth:	11b. State of Birth:	11c. Country of Birth:	12. Gender:
13. What is your GHPP eligible condition?			14. Race/Ethnicity:	
15a. Name of the Genetic Physician Specialist treating your GHPP-eligible condition. Include NPI if known.				
15b. Genetic Physician Specialist's Address:	15c. City			15d. Zip Code:
15e. Phone Number:	16. Name of your Special Care Center Facility:			
17a. Name of the Primary Care Physician who provides coordination of your health care in conjunction with your Genetic Specialist physician. Include NPI if known:				
17b. Phone Number:	17c. Address:	17d. City:		17e. Zip Code:
18. Power of Attorney/Conservator information (if applicable) You must attach supporting documentation.				
Name:	Title:			Phone Number:
Address:	City:			Zip Code:

Section B: Health Insurance Information

19a. Do you have Medi-Cal? ☐ Yes ☐ No

19b. If "Yes", what is your Beneficiary I.D. Card (BIC) number? _____

20a. Do you have Medicare? ☐ Yes ☐ No

20b. If "Yes", what is your Medicare number? _____

20c. Please check all Medicare programs in which you are enrolled:

☐ Part A ☐ Part B ☐ Part C ☐ Part D

21a. Do you have Other Health Insurance? ☐ Yes ☐ No

21b. If "Yes", through: ☐ Your employer ☐ A family member ☐ Retirement benefits

21c. Name of your insurance company: _____

21d. Type of plan: ☐ Preferred Provider (PPO) ☐ Health Maintenance Organization

☐ Other (Specify): _____

21e. Policy number: _____ 21f. Coverage start date: _____

21g. Who pays for the policy? ☐ Employer ☐ Self ☐ Employer and self

☐ Other (Specify): _____

21h. 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 HIPR program to continue reimbursing you? ☐ Yes ☐ No
If you are not currently participating in the HIPR program, would you like reimbursement for your third-party coverage premiums? ☐ Yes ☐ No

21i. Has any of your insurance information changed since the last filing? ☐ Yes ☐ No
If "Yes", explain why: _____
Please attach a copy of the insurance card. To continue your participation in the HIPR program, submit your GHPP renewal application annually.

21j. If your employer provides health insurance and you chose not to participate in your employer's plan, please select the reason below:
☐ The premium is too expensive.
☐ I lost my job, am eligible to continue my coverage under COBRA, and cannot afford to pay the insurance premium.
☐ I have met the lifetime coverage limit of my employer's insurance.
☐ The physician providing care for my condition is not part of my plan's provider network.
☐ Other (specify): _____

21k. During the last six months from the date of this application, has either your employer or yourself terminated your employer's health insurance? ☐ Yes ☐ No

If "Yes", what date was it terminated? _____

Please select the reason for termination below:

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

22. Do you have dental insurance? ☐ Yes ☐ No

If "Yes", name of plan: _____

23. Do you have vision insurance? ☐ Yes ☐ No

If "Yes", name of plan: _____

Section C: Sexual Orientation and Gender Identity

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

24a. What was your sex assigned at birth? (required)

☐ Female ☐ Male ☐ Transgender

24b. What is your gender identity? (optional)

☐ Female ☐ Male ☐ Transgender, male to female ☐ Transgender, female to male

☐ Non-Binary (neither male nor female) ☐ Another gender identity

24c. What gender is listed on your birth certificate? (optional)

☐ Female ☐ Male

24d. Do you think of yourself as? (optional)

☐ Straight or heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Queer

☐ Another sexual orientation ☐ Unknown

Section D: Certification

Read and initial each statement below. Your signature authorizes GHPP to proceed with your application.

_____ 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 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", print name of witness:	Relationship of witness to GHPP applicant:	Witness phone number:

Signature of Witness:	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 by email to GHPPEligibility@dhcs.ca.gov or call (916) 713-8400. By law, the information you give the 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 6250-6288)
3. Section 123800 et. Seq. of the California Health and Safety Code

Instructions for Completing the Genetically Handicapped Persons Program Application to Determine Eligibility

If completing this form by hand, 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 completing this form, please contact the GHPP at (916) 713-8400. Once the application is completed, email it to the GHPP inbox at GHPPEligibility@dhcs.ca.gov or mail the application to Genetically Handicapped Persons Program MS 4507, P.O. Box 997413 Sacramento, CA 95899-7413. Please remember to sign and date this form.

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

1a. **Last Name:** Write your last name. Attach proof of identity to the application, such as a copy of your California driver's license or California identification card.

1b. **First Name:** Write your first name.

1c. **MI:** If you have a middle name, write your middle initial.

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 in your nine-digit Social Security Number.

4a. **Residential Address:** Write your residence street number, street name, and, if applicable, apartment number. Do not use 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

4b. **City:** Write your city of residence.

4c. **County:** Write your county of residence.

4d. **ZIP Code:** Write the Zip Code of residence

5a. **Mailing address (if different):** Write your mailing address, street number, street name, and, if applicable, apartment number.

5b. **City:** Write the city of your mailing address.

5c. **County:** Write the county of your mailing address.

5d. **ZIP Code:** Write the Zip Code of your mailing address.

6. **Phone Number:** Write the telephone number where you can be reached during the day, including the area code.

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

8. **Mother's First and Maiden Name:** Write your mother's first name and maiden name.

9. **Language:** Write the name of the language with which you are most comfortable communicating.

10. **Date of Birth:** Write the month, day, and year of your birth.

11a. **County of Birth:** Write the county in which you were born.

11b. **State of Birth:** Write the state in which you were born.

11c. **Country of Birth:** Write the country in which you were born if you were born outside of the United States.

12. Gender: Fill in your gender (male or female), or see Section 3 to provide more information about your gender, gender identity, gender expression or sexual orientation.

13. 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 • Hemophilia 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)

14. Race/Ethnicity: Write the category from the following list that 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

15a. Name of the Genetic Physician Specialist treating your GHPP-eligible condition. Include NPI if known: Write the name of the physician who provides follow-up care for your GHPP-eligible condition.

15b. Genetic Physician Specialist's address: Write the Genetic Physician Specialist's street number and street name.

15c. City: Write the Genetic Physician Specialist's city.

15d. Zip Code: Write the Genetic Physician Specialist's zip code.

15e. Phone Number: Write the Genetic Physician Specialist's phone number, including the area code.

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

17a. Name of the Primary Care Physician who provides coordination of your health care in conjunction with your Genetic Specialist physician. Include NPI if known: Write the name of your Primary Care Physician.

17b. Phone Number: Write the phone number of your Primary Care Physician.

17c. Address: Write your Primary Care Physician's street number and street name.

17d. City: Write your Primary Care Physician's city.

17e. Zip Code: Write your Primary Care Physician's zip code.

18. 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 or Conservator), phone number, address (street number and name), city, and zip code 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 been paid.

19a. Do you have Medi-Cal? Select the correct response (Yes or No).

19b. If "Yes", what is your Beneficiary I.D. Card (BIC) number? Write the Medi-Cal number located on the front of your Beneficiary I.D. Card (BIC).

20a. Do you have Medicare? Select the correct response (Yes or No).

20b. If "Yes", what is your Medicare number? Write your Medicare I.D. number.

20c. Please check all Medicare Programs in which you are enrolled: Check all that apply (Parts A, B, C, and/or D).

21a. Do you have Other Health Insurance? Check the correct response (Yes or No).

21b. If "Yes", through: Select the source of your insurance, either through your employer, through a family member, or through your retirement benefits.

21c. Name of your insurance company: Write the full name of your insurance company (i.e., Kaiser Permanente, Blue Cross of California, etc.) Attach a copy of both front and back of your insurance card.

21d. Type of Plan: Select the response that matches the type of plan you have- Preferred Provider PPO, Health Maintenance Organization (HMO), or Other. If other, specify in the provided field.

21e. Policy number: Write your insurance policy number.

21f. Coverage start date: Write the start date of your insurance coverage.

21g. Who pays for the policy? Select the response that indicates who pays for your insurance policy- either your employer, yourself, both your employer and yourself, or other. If you select "Other", specify in the provided field.

21h. 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?
Select the correct response (Yes or No).

If "Yes", would you like the HIPR program to continue reimbursing you? Select the correct response (Yes or No).

If you are not currently participating in the HIPR program would you like reimbursement for your third-party coverage premiums? Select the correct response (Yes or No)

21i. Has any of your insurance information changed since the last filing? Select the correct response (Yes or No).

If "Yes", explain why: In the field, write an explanation for why your insurance information has changed since last filing a GHPP application. You must attach a copy of your insurance card. You must renew your GHPP enrollment in order to continue participation in the HIPR program.

21j. If your employer provides health insurance and you choose not to participate in your Employer's plan, please select the reason below: Select the response that explains why you choose not to participate. If you select "Other", explain in the provided field.

21k. During the last six months from the date of this application, has either your employer or yourself terminated your employer's health insurance? Select the correct response (Yes or No).

If "Yes", what date was it terminated? If yes, write the date the insurance was terminated, and select the reason why it was terminated. If you select "Other" as the reason why it was terminated, specify why in the provided field.

22. Do you have dental insurance? Select the correct response (Yes or No).
If "Yes", name of plan: Write in the name of the dental plan.

23. Do you have vision insurance? Select the correct response (Yes or No)
If "Yes", name of plan: Write in the name of the vision plan.

Section 3: Sexual Orientation and Gender Identity.

24a. What was your sex assigned at birth? (required): Select the correct response. This question is required.

24b. What is your gender identity? (optional): Select the correct response. You are not required to answer this question.

24c. What gender is listed on your birth certificate? (optional): Select the correct response. You are not required to answer this question.

24d. Do you think of yourself as? (optional): Select the correct response. You are not required to answer this question.

Section 4: Certification.

Read and initial the statements where indicated on the form. then sign and date in ink, if writing by hand, or by using digital signature if filling out electronically. If you sign your name with an "X", you must have a witness sign in the space indicated.

Submitting your application.

Send the completed form DHCS 4000 A along with succeeding form DHCS 4000 B (Genetically Handicapped Persons Program Initial/Annual Income Verification) and include copies of:

- Photo Identification (California Driver's License (CDL), California Identification (ID), Passport, or Student ID)
- Proof of CA residency (utility bill, lease agreement, voter registration, etc.)
- Proof of Income (most recent year 1040 tax forms, SSI/EDD statement, etc.)
- (NEW APPLICATIONS ONLY) Medical records with specific GHPP-Eligible diagnosis and genetic lab testing results that support your GHPP-Eligible condition

Send by email to GHPPEligibility@dhcs.ca.gov or by postal mail to: Genetically Handicapped Persons Program, MS 4507
P.O. Box 997413
Sacramento, CA 95899-7413

Genetically Handicapped Persons Program Initial/Annual Income Verification

Refer to the instructions on pages 11 and 12 when completing this form. the following information is required by The Genetically Handicapped Persons Program (GHPP) to determine your enrollment fee amount, if any. Your enrollment fee is based upon your family gross income for the previous calendar year. Your income information is reviewed annually, and therefore your enrollment fee may change from year to year.

Please provide all 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 GHPP at GHPPEligibility@dhcs.ca.gov or call (916) 713-8400.

Section A: Personal Information				
1a. Last Name:	1b. First Name:	1c. MI:	2. Social Security Number (optional):	
3a. Residential Address:	3b. City:	3c. County:		3d. Zip Code:
4. Day Phone Number:		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: _____

Name: _____ Relationship: _____

9. Employment Information

Your Employer's Name: _____

Address: _____ City: _____ Zip Code: _____

Employer's Phone: _____

Section C: Enrollment Fee Information

Notification of enrollment fee status:
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:

a. One lump sum due no later than the 60th day from the date of notification from the GHPP, or
b. Two or three payments which are due no later than the 60th, 120th, and 180th days from the date of notification from the GHPP.

Failure to pay the enrollment fee according to the signed agreement will result in the 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.			
Signature of GHPP applicant or parent/legal guardian of minor/child:		Relationship to minor/child:	Date:
If signing with an "X", print name of witness:	Relationship of witness to GHPP applicant:		Witness phone number:
Signature of Witness:			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 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 (916) 713-8400. 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

Instructions for Completing the Genetically Handicapped Persons Program Initial/Annual Income Verification Form

If completing this form by hand, 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 requested information requested, the GHPP will be unable to proceed with your application. If you need help in completing this form, please contact the GHPP at (916) 713-8400. Once the application is completed, email it to the GHPP inbox at GHPPEligibility@dhcs.ca.gov or mail the application to Genetically Handicapped Persons Program MS 4507, P.O. Box 997413, Sacramento, CA 95899-7413. Please remember to sign and date this form.

Section A: Personal Information

This includes identifying information and other information necessary to process this form.

1a. **Last Name:** Write your last name. Attach proof of identity to the application, such as a copy of your California driver's license or California identification card.

1b. **First Name:** Write your first name.

1c. **MI:** If you have a middle name, write your middle initial.

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

3a. **Residential Address:** Write your residence street number, street name, and apartment number.

3b. **City:** Write your residence city.

3c. **County:** Write your residence county.

3d. **Zip Code:** Write your residence zip code.

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

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

Section B: Income Verification

Your enrollment fee, if any, will be based on the information you provide in this section.

6. **Family Gross Income:** Enter dollar amount. 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:** Write the number of family members, including yourself. 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, phone number, and address.

Section C: Enrollment Fee Information

Please read the important information in this section regarding your enrollment fee.

Section D: Certification

Read and initial the statements where indicated on the form. Then sign and date in ink, if writing by hand, or by using digital signature if filling out electronically. If you sign your name with an "X", you must have a witness sign in the space indicated.

Submitting your application

Send the completed form DHCS 4000 B along with the preceding form DHCS 4000 A (Genetically Handicapped Persons Program Application to Determine Eligibility) and include copies of:

- Photo Identification (California Driver's License (CDL), California Identification (ID), Passport, or Student ID)
- Proof of CA residency (utility bill, lease agreement, voter registration, etc.)
- Proof of Income (most recent year 1040 tax forms, SSI/EDD statement, etc.)
- (NEW APPLICATIONS ONLY) Medical records with specific GHPP-Eligible diagnosis and genetic lab testing results that support your GHPP-Eligible condition

Send by email to GHPPEligibility@dhcs.ca.gov or by postal mail to:
Genetically Handicapped Persons Program, MS 4507
P.O. Box 997413
Sacramento, CA 95899-7413

Privacy Notice on Collection

This privacy notice is required by California Civil Code section 1798.17. The purpose of this form is to collect information for enrollment in the Genetically Handicapped Persons Program (GHPP). The personal and/or medical information collected in this form 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).