GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) NEW REFERRAL FORM

DATE: _____

CLIENT INFORMATION

NAME: _____ DOB: _____ SEX: M___ F___

GHPP ELIGIBLE CONDITION: _____

RESIDENTIAL ADDRESS:

_____

_____

_____

MAILING ADDRESS:

_____

_____

PHONE #: _____

MOTHER'S FIRST AND MAIDEN NAME:

_____

SSN: _____
(OPTIONAL)

MED-CAL #: _____

MEDI-CARE #: _____

OTHER HEALTH COVERAGE:

(MEDICAL) _____

(VISION) _____

(DENTAL) _____

BIRTHPLACE: (CITY, COUNTY, STATE/COUNTRY)

_____

REFERRING PERSON/AGENCY: _____

TELEPHONE NUMBER: _____ FAX: _____

FOR CALIFORNIA CHILDREN SERVICES (CCS) USE ONLY

COUNTY: _____

CONTACT PERSON: _____

PHONE NUMBER: _____

FAX NUMBER: _____

CHILD'S CCS NUMBER: _____

CHILD'S SPECIAL CARE CENTER:

_____

_____

ATTACHMENTS (PLEASE CHECK)

- ☐ MOST RECENT SCC ANNUAL REPORTS
- ☐ DNA TEST RESULT OR OTHER TEST CONFIRMING GHPP ELIGIBLE CONDITION
- ☐ INFORMATION ABOUT UPCOMING SURGERIES/TRANSPLANTS

PLEASE FAX TO THE GHPP AT 916-327-1112

The information requested on this form is required by the Department of Health Care Services, Children's Medical Services Branch, GHPP Unit for purposes of identification and enrollment processing. Failure to provide the requested information may result in delay of GHPP enrollment.