SAN FRANCISCO STATE UNIVERSITY

CSU Employee Fee Waiver and Reduction Program
Disabled Dependent Eligibility Form

Dependent Fee Waiver Criteria: A dependent child for fee waiver eligibility is defined as (a) your child or stepchild under age 25* who has never been married; (b) a child living with you in a parent-child relationship who is economically dependent upon you, under age 25* and has never been married; or **(c) your child or stepchild age 25* or above who is incapable of self-support due to a disability which existed prior to age 25.**

***** For Unit 1 (Physicians) and Unit 8 (Police Officers), the age limit for dependent children is under age 23 using the same definitions above.

Requesting Dependent Fee Waiver Eligibility on the Basis of Disability

If you are requesting Dependent Fee Waiver eligibility for your child based on (c) above, please complete this form (Sections A, B, and C). If you answer no to the question in Section C, please also have your child's physician complete section D. Return the completed form to the Fee Waiver Coordinator in Human Resources, ADM 252.

This form must be completed and submitted to the Fee Waiver Coordinator **annually** in order to maintain eligibility for your child on the basis of disability.

Section A – Employee Information

Employee's Name:	
Employee ID Number:	

Section B – Dependent Information

Dependent Child's Name:	
Date of Birth:	

Section C – CalPERS disabled dependent benefit

Is your child currently enrolled in health benefits under the CalPERS disabled dependent benefit?

☐ **YES**: No physician's certification is necessary – submit this completed form to the Fee Waiver Coordinator

☐ **NO**: Have your child's physician complete Section D – Physician's Certification of Disability and Incapacity of Self-Support

I hereby certify that the information provided by me is true and correct to the best of my knowledge. I understand that eligibility must be recertified upon expiration of this form.

Employee Signature _____ **Date** _____

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Section D – Physician's Certification of Disability and Incapacity of Self-Support

To Be Completed/Signed by both the Employee and Dependent Child (Patient):

Name of Patient:	
Date of Birth:	
Social Security Number:	
Name of CSU Employee:	

The patient named above is seeking educational assistance benefits as a qualifying dependent child of a CSU employee. Both your patient and our employee hereby provide permission for you to complete and release the information requested below so that we may determine your patient's eligibility for these benefits.

_____ _____

Dependent Child/Patient's Signature or person authorized to act on his/her behalf **Date**

_____ _____

CSU Employee/Parent's Signature **Date**

PRIVACY NOTICE

The Information Practices Act of 1977 and the Federal Privacy Act require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by CSU-SFSU Benefits Administration solely for the purpose of determining eligibility as a dependent for the CSU employee fee waiver program. Failure to supply the information may result in CSU-SFSU Benefits Administration being unable to authorize the use of the CSU dependent fee waiver benefit. This form is maintained in confidential files in the CSU-SFSU Human Resources office for one year.

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To Be Completed/Signed by the Patient's Physician:

For purposes of this educational assistance benefit, a CSU employee's dependent child can retain his or her eligibility for Dependent Fee Waiver if he or she is incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 25 years of age (the age limit for dependent children is under age 23 using the same definitions above for employees in bargaining units 1 - Physicians and 8 - Police Officers).

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness, or condition?

☐ **YES**: Date the disability commenced: _____

☐ **NO**, the patient does NOT have a physically or mentally disabling injury, illness, or condition.

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:

☐ **A** The patient's current disability DOES NOT render him or her incapable of self-support.

☐ **B** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by:

_____ PROJECTED DATE (mm/yy)

☐ **C** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than 5 years).

I hereby certify that the information provided by me is true and correct to the best of my knowledge.

Physician Signature _____ **Date** _____

PRINT, TYPE OF STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE AND HIS OR HER ADDRESS, TELEPHONE, AND FAX NUMBERS:

PHYSICIAN'S NAME AS SHOWN ON LICENSE	STATE LICENSE NUMBER
LOCAL ADDRESS	TELEPHONE NUMBER
CITY, STATE ZIP	FAX NUMBER

Section E – HR USE ONLY

☐ Eligibility approved through _____ _____

DATE (for next review) REVIEWED BY

☐ Eligibility denied _____

DATE