MEDICAL MARIJUANA CAREGIVER APPLICATION

Mail Completed Application to: Delaware Division of Public Health ATTN: MMP, Suite 130 417 Federal Street Dover, DE 19901	☐ New Caregiver	☐ Renewing Caregiver
	Have you ever applied for a Medical Marijuana Id card?	☐ Yes ☐ No

Print clearly. Incomplete applications may be denied. Denied applicants are required to wait six months before beginning the application process again. Application fees are non-refundable. . ***Faxed and electronic copies of applications will not be accepted***.

CAREGIVER CONTACT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:** *(Must be 21 or Older)*
Address: *(Street, Apt. #)*		
Address: *(City, State, ZIP Code)*		
Have you ever lived in any states outside of Delaware?	☐ No ☐ Yes (If yes, list previous states lived in and when below.)	
Primary Phone:	☐ Check this box if a confidential message may be left at this number.	
Secondary Phone:	☐ Check this box if a confidential message may be left at this number.	
Email Address: *(Optional)*	☐ Check this box if confidential information may be shared by email.	

PATIENT INFORMATION

A caregiver must complete this application for each patient they request to assist with the medical use of marijuana. A caregiver may have up to five (5) patients, including himself/herself if the caregiver is also a registered patient in the Medical Marijuana Program. The patient must complete the "Patient Authorization" portion of the application.

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:** *(Must be 18 or Older)*
Address: *(Street, Apt. #)*		
Address: *(City, State, ZIP Code)*		
Primary Phone:		
Patient Relationship to Caregiver:	**Patient's Medical Marijuana Registry ID # if known:**	

CAREGIVER APPLICATION CHECKLIST

☐	**Did you initial all six (6) of the Caregiver Attestation Statements and sign on the signature line? (Page 2)**
☐	**Did you include the Patient Authorization form completed and signed by the patient? (Page 4)**
☐	**Did you include a legible copy of your Delaware driver's license or state-issued identification?**
☐	**Did you include your receipt from Delaware State Bureau of Identification (SBI) showing proof that you have requested a statewide and nationwide criminal history screening background clearance report to be sent to the Delaware Office of Medical Marijuana (OMM)?**
☐	**Did you include the non-refundable application fee, or your signed Low Income Charge Request form with supporting documentation? Please make check or money order payable to State of Delaware, MMP**

PATIENT AUTHORIZATION FORM

AUTHORIZATION FOR CAREGIVER

I _____, (patient), hereby authorize the following person to be my designated caregiver for the Delaware Medical Marijuana Program. I authorize this caregiver to assist me in the transportation and storage of my medical marijuana. This person will be responsible for managing my well-being with respect to the use of medical marijuana.

Caregiver's First Name: _____ Last Name: _____

Caregiver's Date of Birth: _____
(Must be 21 or Older) *mm/dd/yyyy*

This authorization will expire with the expiration of the patient's registry card and will need to be reauthorized with each caregiver renewal.

_____ _____
Patient's Signature Date

CAREGIVER'S ATTESTATION STATEMENT

By signing below, the Caregiver certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Medical Marijuana Caregiver Registry Card. If approved for the Registry Card, the Caregiver acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A.

* ***To ensure confidentiality, information regarding application status will not be given over the phone.*** Once applications are processed, communication will be sent to the Caregiver's residence with further instructions for the finalization of the Registry Card.
* Applicants are required by law to notify the DPH Office of Medical Marijuana with any changes in information within 10 days of the change. Failure to do so can result in fines.
* Any registry card that is lost or stolen must be reported to DPH Office of Medical Marijuana immediately.
* Caregiver/Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued and is subject to the card re-issue fee.

_____ *initial*	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
_____ *initial*	I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
_____ *initial*	I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.
_____ *initial*	I will assist, _____, a qualified medical marijuana patient, with the medical use of marijuana. I am caring for no more than five (5) patients in this manner.
_____ *initial*	I attest that I have not been convicted of an excluded felony offense as defined in Title 16, Chapter 49A – The Delaware Medical Marijuana Act.
_____ *initial*	I understand that if the patient's registry identification card expires, then my caregiver card for this patient shall also expire. I agree to return my primary caregiver card to the DPH Office of Medical Marijuana if and when my patient(s) is(are) no longer eligible for the program or if my patient(s) change(s) caregivers.

_____ Caregiver Signature	_____ Date of Signature

VOLUNTARY DEMOGRAPHIC INFORMATION

Your voluntary answers are requested - check the items that apply. It is the policy of the State of Delaware to assure equal and fair treatment in all aspects of healthcare for all Delaware residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected. De-identified patient information is used for research purposes. Aggregate, de-identified patient information can be published and shared with third parties.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Partnership

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race:
☐ Caucasian / White ☐ African American / Black
☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander ☐ Other _____

Language:
How well do you speak English?
☐ Very Well ☐ Well ☐ Not Well ☐ Not at All
Do you speak another language other than English at home?
☐ No ☐ Yes, Spanish ☐ Yes, not Spanish, specify _____

Veteran Status:
Are you a United States veteran?
☐ No ☐ Yes

Citizenship:
Are you a citizen or lawful resident of the United States of America?
☐ No ☐ Yes

Education:
What is your highest level of education completed?
☐ Some High School Completed ☐ Technical School
☐ High School Diploma / GED ☐ University / 4-Yr College
☐ Community College / 2-Yr Degree ☐ Master Program or Above
Are you currently enrolled in school?
☐ No ☐ Yes, please specify: _____

Employment:
Are you currently employed?
☐ No ☐ Yes, part-time ☐ Yes, full-time
What is your current occupation? _____

Income:
What is your annual household income?
☐ Less than $19,999 ☐ $60,000 to $79,999
☐ $20,000 to $39,999 ☐ $80,000 to $99,999
☐ $40,000 to $59,999 ☐ $100,000 or above

Public Assistance:
Are you currently enrolled in a public assistance program such as food supplement program or any other?
☐ No ☐ Yes, please specify: _____