DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Medical Marijuana

For the most current information regarding this application, medical marijuana laws in the State of Delaware, and more see the official website:
http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html

PEDIATRIC MEDICAL MARIJUANA PATIENT APPLICATION

Mail Completed Application to: Delaware Division of Public Health ATTN: MMP, Suite 140 417 Federal Street Dover, DE 19901	☐ New Pediatric Patient	☐ Renewing Pediatric Patient
	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***.

PEDIATRIC (AGE 17 OR YOUNGER) PATIENT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		

PRIMARY PARENT/GUARDIAN INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Secondary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Relationship to Applicant:		☐ Check this box if confidential information may be shared by email.
Email Address: ***(Optional)***		

SECONDARY PARENT/GUARDIAN INFORMATION (OPTIONAL – ONLY IF SECOND CAREGIVER CARD REQUIRED)

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address: *(Street)*		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Secondary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ 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.
Relationship to Applicant:		

APPLICATION CHECKLIST

☐	**Did both guardians initial all three of the Attestation Statements and sign on the signature line? (Page 2)**
☐	**Did you include the Physician Certification forms completed and signed by the patient's physician? (Pages 4-5)**
☐	**Did the primary guardian sign the Release of Medical Information form? (Page 6)**
☐	**Did both guardians include a legible copy of their Delaware driver's license or state-issued identification?**
☐	**Did you include the $125.00 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**

MEDICAL MARIJUANA PROGRAM KEY POINTS

The Division of Public Health (DPH), authorized by 16 Del.C.Ch.49A - Delaware's Medical Marijuana Act, regulates the state's Medical Marijuana Program (MMP). As an applicant to the Medical Marijuana Program, patients, caregivers, agents, and compassion center staff are responsible for reading this act and following the stipulations within it. For a complete copy of the Delaware Medical Marijuana Act, contact the DPH Office of Medical Marijuana, visit our website, or download it directly from the web at: http://delcode.delaware.gov/title16/c049a/index.shtml

FINES ESTABLISHED FOR NON-COMPLIANCE

The following fines have been established in the Medical Marijuana Act:

Failure to notify program staff of patient / caregiver changes in information	$	150.00
Dispersing marijuana to a non-card holder	$	2,000.00
Fraudulent card creation or use	$	1,150.00
Unethical professional conduct	$	3,000.00

FEE SCHEDULE

The following fee schedule has been established in the Medical Marijuana Act. Applicants must include payment with the completed application payable to the State of Delaware, Medical Marijuana Program. Applicants can apply for an application fee waiver by completing a Low Income Charge Request form. Contact the Office of Medical Marijuana to obtain this form and submit with the application. Failure to submit payment or Low Income Charge Request with the application may result in denial of application or delay in processing.

Patient Application Fee (registration effective for one year from issue date)	$	125.00
Patient Renewal Fee	$	125.00
Pediatric Patient Application Fee (includes parent/guardian fees)	$	125.00
Pediatric Patient Renewal Fee	$	125.00
Caregiver Application Fee	$	125.00
Caregiver Renewal Fee	$	125.00
Return Check Fee	$	35.00
Card Re-Issue Fee	$	20.00

PARENT/GUARDIAN'S ATTESTATION STATEMENT

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

* To ensure confidentiality, information regarding application status will not be given over the phone. Once applications are processed, communication will be sent to the Pediatric Patient's residence with further instructions for the finalization of the Registry Card.
* Parents/guardians of pediatric patients are required by law to notify DPH Office of Medical Marijuana with any changes in information (such as address, phone number, program eligibility, etc.) 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.
* Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued.

_____ *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.

_____ Parent/Guardian Signature	_____ Date of Signature

PARENT/GUARDIAN 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: _____

PEDIATRIC PHYSICIAN CERTIFICATION

PATIENT'S INSTRUCTIONS: The patient's pediatric specialty physician will complete this entire section. Only a pediatric neurologist, a pediatric gastroenterologist, a pediatric oncologist, or a pediatric palliative are specialist can certify for patients age 17 and under.

This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Division of Public Health Medical Marijuana Office, within 90 days of the physician's signature date.** *Faxed and electronic copies will not be accepted.*

PHYSICIAN'S INSTRUCTIONS: Print clearly and answer all of the questions with information in the patient's medical record. ***Attach copies of medical records showing diagnosis of patient's qualifying medical condition; underlying causes; previous treatments and their results; and treatment plans for the future.***

(A) PEDIATRIC PATIENT INFORMATION

Name: *(Last, First, M.I.)* ☐ M ☐ F	**Date of Birth:**

(B) PEDIATRIC PHYSICIAN INFORMATION (MUST be a pediatric neurologist, a pediatric gastroenterologist, a pediatric oncologist, a pediatric palliative care specialist, a Pediatric Psychiatrist, or a Developmental Pediatrician)

Name: *(Title, First, MI, Last, Suffix)*		**Medical License Number:**
Address: *(Street, Building, Suite #)*		**License State:** *(Must be licensed in Delaware)*
Address: *(City, State, ZIP Code)*		**License Type:** *(Must be DO or MD)*
Pediatric Specialty: ☐ Pediatric Neurologist ☐ Pediatric Gastroenterologist ☐ Pediatric Oncologist ☐ Pediatric Palliative Care Specialist ☐ Pediatric Psychiatrist ☐ Developmental Pediatrician		
Phone:	**Fax:**	**Email:** *(not required)*

(C) DEBILITATING MEDICAL CONDITION

Listed below are the ONLY qualifying debilitating medical conditions for pediatric patients
☐ Seizure Disorder
☐ Severe Debilitating Autism
☐ Terminal Illness involving Pain, Anxiety or Depression that is related to the Terminal Illness
☐ A chronic or debilitating disease or medical condition where they have failed treatment involving one or more of the following symptoms:
☐ cachexia or wasting syndrome
☐ intractable nausea
☐ severe, painful and persistent muscle spasms
Comments: Provide a short description of patient's qualifying medical condition.

Physician's Signature (no signature stamps accepted)	Date

PHYSICIAN CERTIFICATION (CONTINUED)

PHYSICIAN CERTIFICATION

I have established a bona fide physician-patient relationship with _____, (patient) beginning _____ (date of first patient visit to your office). This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form	_____ *Physician Initials*
I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed in accordance with Title 16, Chapter 49A of the Delaware Code (4902A(3).	_____ *Physician Initials*
I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians for the qualifying condition. I have established a medical record of the qualifying patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical marijuana treatment.	_____ *Physician Initials*
I have explained the potential risks and benefits, as they are known to me, of the medical use of marijuana to the qualifying patient and parent/guardian.	_____ *Physician Initials*
I have assessed this patient for history of substance use disorder.	_____ *Physician Initials*
If a history of substance abuse has been identified. The Department of Health and Social Services (DHSS) requests your acknowledgement of the history of substance abuse, and your confirmation that medical marijuana is an appropriate treatment option to include a commitment to monitor patient closely. (Please initial here if indicated).	_____ *Physician Initials*

Physician's Attestation

I _____, (physician), hereby certify that I am a physician duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's qualifying debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

I attest that the information provide in this written certification is true and correct.

_____ Physician's Signature (no signature stamps accepted)

_____ Date

Comments: Provide any additional information that would be useful in assessing this patient's application to the Delaware Medical Marijuana Program.

PATIENT RELEASE OF MEDICAL INFORMATION

PARENT/GUARDIAN'S INSTRUCTIONS: Complete and sign the following release statement on behalf of the pediatric patient. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician(s) relating to the qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied. Faxed and electronic copies will not be accepted.

PARENT/GUARDIAN RELEASE REQUEST

I _____, (parent/guardian), hereby authorize the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Office of Medical Marijuana (OMM) to discuss my child's _____, (pediatric patient) medical condition, including treatment records, test results, and evaluations specific to _____, (patient's qualifying condition), with my child's certifying medical provider: _____, (pediatric physician's full name).

I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Delaware Office of Medical Marijuana, and that revocation may result in the inability of the program to certify my child as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to the information that has already been released in response to this authorization.

The information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form is not necessary in order to receive treatment from the Delaware Department of Health and Social Services. This release is required; however, to verify my child's eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my child's enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program administrator or designee has reason to believe that a qualified patient-applicant may have violated an applicable law.

This authorization will expire one (1) year from the date signed below unless a different expiration date, less than one (1) year, is specified here: _____.

_____ _____

Parent/Guardian's Signature Date