Delaware Medical Marijuana Act Annual Report

State Fiscal Year

2013

This report is a snapshot of Delaware's Medical Marijuana Program in its first year. The compassion centers were suspended, so the focus is on the issuance of registry cards. Thirty seven cards were issued, one being a caregiver. The application procedures and forms are included. Education and outreach achievements are explained. Program participation levels are presented in various ways, including informative charts indicating participation by gender, age, county and medical conditions. Interagency coordination efforts and initiatives for moving forward once the compassion center suspension is lifted are all outlined in this report.

Program Year 1

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Delaware Medical Marijuana Program Annual Report

Program Year 1 *July 1, 2012 - Jun 30, 2013 (FY 2013)*

I. Introduction

The Delaware Medical Marijuana Act (hereafter referred to as *the Act*), Chapter 49a of Title 16 of Delaware Code, was approved and signed by Governor Jack Markell on May 13, 2011. It took effect on July 1, 2011. In February 2012, the portion of the law that called for the establishment of three compassion centers, one in each county, was suspended based on guidance from the US Attorney; however, the patient and caregiver registry card program continued to be developed. This report is submitted in response to paragraph §4922A(b) of the Act.

The purpose of this report is to update the Division of Public Health (DPH) on the first year's activities, and to outline the operating efforts established and maintained during the prior fiscal year and the result of those efforts.

Applications	Patients	Caregivers
Approved	37	1
Denied	4	0
Other	6	7

Table I-1: Number of applications processed.

The Department of Health and Social Services (DHSS) implemented the Medical Marijuana Program (MMP) on July 1, 2012. The first registration cards were issued to qualified patients and their designated caregivers in September 2012. As of June 30, 2013, 36 registration cards have been issued to patients with qualifying medical conditions. Only one registration card has been issued to a qualified, designated caregiver. During the first fiscal year of the program, the Department denied four patient applications due to the absence of a Physician Certification form completed and signed by a Delaware-licensed physician.

In response to the Act, revenue from the MMP was to cover the expenses of the program. Appropriated Special Funds spending authority, in the amount of $480,000, was allocated for personnel and the costs of necessary equipment and supplies. A registration fee of $125 was implemented after studying other states' medical marijuana program fees and considering the expected fees from three Compassion Centers. Community input demonstrated a need for a reduced fee for individuals with a lower fixed income. DHSS Policy Memorandum 37 (PM37) establishes a sliding scale based on the Federal Government Poverty Guidelines. Applicants who submit satisfactory evidence to the Department of gross annual household income within that sliding scale are approved to pay a percentage of the total registration fee as established by the policy. Only about half (45%) of the applications received were accompanied by the full $125 application fee. Actual direct personnel and expense costs for the program totaled $131,000 for fiscal year 2013. The Department collected a total of $3,500 in registration fees. It would be unrealistic to charge patient and/or caregivers at a rate that would cover the program expenses.

Revenue	Expenses
$3,500	($131,000)

Table I-2: Revenue & Expenses

II. Education and Outreach

The Health Systems Protection (HSP) section of DPH is responsible for the policy development and operation of the MMP. The Office of Medical Marijuana (OMM) coordinated the establishment of both a designated program phone number and a program resource e-mail account with which the public may contact the program.

During the first year of operation, OMM answered over 600 calls and replied to nearly 300 emails from potential program patients and caregivers, physicians and their staff, interested compassion center owners, college researchers and the general public. OMM provided information, assistance, and materials to callers requesting to apply for the Medical Marijuana patient or caregiver registry card. They also provided assistance to physicians and their office staff wishing to confirm the program and its policies. Finally they provided general information to school researchers who were writing papers on the use of medical marijuana.

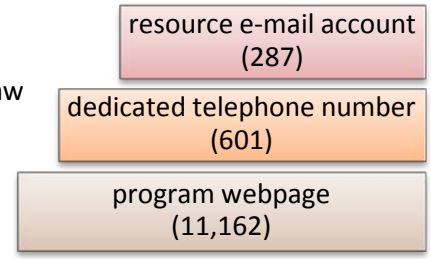


Chart II-1: Incoming correspondence

In an attempt to direct the general public to the online text of the law and the correlating regulatory code, OMM established a webpage for the program as well. The webpage contained the contact information for the MMP and links to both the law and the code related to the program. OMM coordinated the posting of this new webpage, and links to it from the HSP webpage, and other locations on DPH's website. The URL for the page is http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html.

The standard non-refundable application fee was $125. This is for all applications for a registry card, patients and caregivers, new and renewing. Many of the applicants to the MMP are, as a result of their disabling medical condition, receiving disability benefits from the Social Security Administration as their only means of income. A sliding scale for this application fee was established based on the existing model used in other DHSS programs, following the guidance in DHSS PM37: *Standard Ability to Pay*. This scale takes in to account the annual household income of the applicant and, comparing it to the gross annual household income chart listed in the Poverty Guidelines set by the Federal Government, adjusts the $125 application fee according to the scale established. This policy allows those patients whose financial circumstances have been affected by the very condition that qualifies them for this program to apply and pay the application fee according to their ability to do so. You can review the sliding scale in Appendix A on page 8 of this report; the numbers are updated every year after the new poverty guidelines are published, usually in March. The appendix shows the tables for 2012 and 2013.

III. Compliance Activities

HSP is responsible for the overall implementation and maintenance of the MMP established in the Act. OMM drafted the regulations for the Act after careful review of the law and other states' regulations whose medical marijuana laws are similar to Delaware's. The regulations were promulgated through the normal process and posted as final in the June 1, 2012 issue of the state Register of Regulations. They became effective July 1, 2012. You can find those regulations in the previous register issues on the

registrar's webpage along with the public comments that were submitted and their responses. OMM developed program policies and procedures and began logging constituent communication and participation.

Program Development

OMM developed application forms for patients and caregivers, to facilitate the process of applying for the registry card. The Physician Certification Form (in Figure D-5 of Appendix D) is completed and signed by the Delaware-licensed physician who is treating the applicant. It contains a series of attestation statements that the doctor initials before they sign the bottom. Other forms developed include a Patient Application, a Release of Medical Information, a Caregiver Application, and a Low Income Fee Request. In addition to contact and demographic data collected on the forms, the card applicant also signs attestation statements indicating that they will not divert marijuana to non-card holders and will abide by the rules of the program. The application forms used this year are included in Appendix D beginning on page 11.

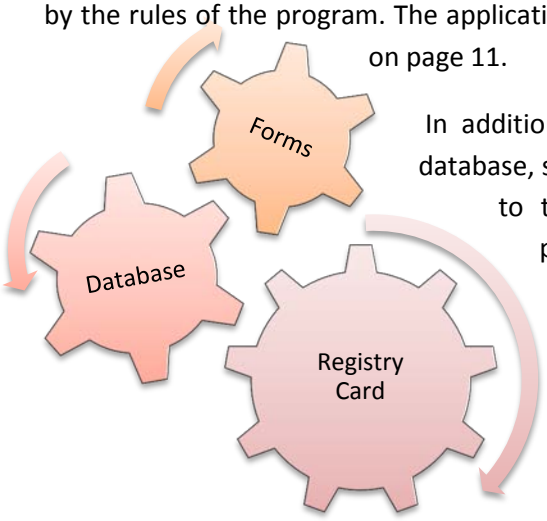


Chart III-1: Parts of the MMP program designed and created to work together.

In addition to the forms, OMM created a password protected Excel database, secured in a limited-access folder that is backed up each night, to track the details of patients, caregivers, applications, and physicians. Each MMP applicant receives a randomly generated unique identification number, as established in the Act, and details related to the applicant are stored in a worksheet in the MMP database workbook. Similarly, each application submitted receives a unique identifying number and the details and dates related to that application instance are logged in another worksheet. Physician information is maintained in a third worksheet, and financial information in a fourth, all in the MMP database workbook which requires specific permissions to access.

In order to issue a program registry card to the approved patients and caregivers, a template was created using existing in-house publishing software. The card contains a picture of the card holder, taken by OMM, the name, address, and birthdate of the cardholder, the issue and expiration date of the card, and the unique program identification number for the cardholder. If the card belongs to a caregiver, the card also contains the unique program identification number(s) of the caregiver's patient(s) – up to five as allowed by the Act. The card is printed and laminated with laminate jackets that are printed with ultra violet text identifying the department, division, and section. Samples of both the patient and caregiver cards are included in Appendix E.

Registry Card Application Procedure

The registry card application process begins with application forms obtained from OMM. The doctor, patient and optional caregiver complete and sign the application forms and mail them back to the program where they are processed, reviewed, and filed. If approved, the patient goes to OMM to pick

up their card. If denied, a letter is sent to the patient with reason for denial. This process is repeated in its entirety when the card holder is ready to renew his registration a year later. The remainder of this section details this registration process as it has been deployed for fiscal year 2013.

A qualifying person wishing to apply to the MMP would do so by first obtaining the application forms from OMM. They can do that by calling the medical marijuana phone number, or by emailing the resource email account, and requesting the forms to be mailed to their home, or to have the Portable Document Format (PDF) documents attached to an email. The patient takes the Physician Certification to their doctor to complete and sign. The applicant then completes the Patient Application and signs the Medical Records Release form.

The applicant then sends the completed application to OMM, along with a copy of their Delaware-issued

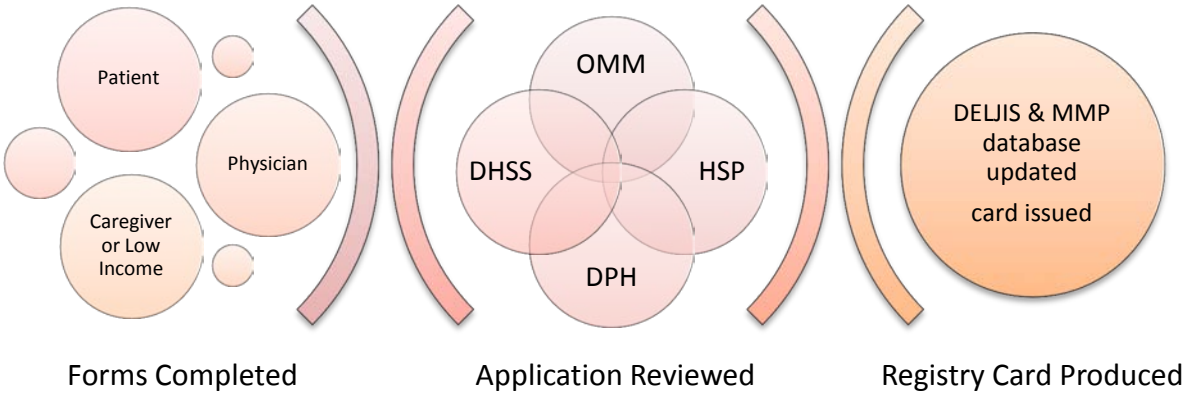


Chart III-2: Stakeholders, procedures, and outputs of the MMP registry card application process.

driver's license or identification card and the application fee. If the applicant is part of a low income household and wishes to be considered for a low income fee based on their annual household income, they would submit the supporting documents to prove their annual income along with a signed letter indicating that they cannot pay the full application fee. If the patient wishes to have a caregiver enrolled in the registry program, they would also submit the Caregiver Application, completed and signed by the caregiver. Caregivers must obtain a background check from the State Bureau of Identification (SBI) and the Federal Bureau of Investigation (FBI) in order to be considered for registration as a caregiver (see the Interagency Coordination section of this report for more information on that process).

Once the complete application is received by OMM, it is prepared for review. All information about the applicant, the application, the physician, and fiscal transactions is logged into the secure MMP Excel database. The certifying physician's state medical license is verified online with the Delaware Division of Professional Regulation to be active and in good standing. The doctor's office is called to validate the physician's signature and the patient information on the physician certification. The application file is reviewed and either approved or denied by the MMP Program Manager, the HSP Section Chief, the DPH Division Director, and finally the DHSS Department Secretary.

After review and approval, OMM schedules the final transaction. If an application is denied, a letter of denial is prepared, signed by the Program Manager and mailed to the applicant. If it is approved, a letter of approval is prepared, including an appointment time for the applicant's final transaction, and mailed to the applicant. During that final transaction appointment, the applicant's picture will be taken and the registry card will be produced and issued.

Constituent Communication

The Office of Medical Marijuana (OMM) logged all calls and emails that came into the program, and noted the number of monthly visits to the webpage as reported by DPH's website staff. Over the course of Fiscal Year 2013, approximately 900 contacts were logged, averaging about 50 phone calls and 25 emails per month. The majority of those calls and emails were from potential or current applicants, but OMM also fielded calls from other states' program facilitators, researchers, physician's offices, advocacy groups, potential compassion center owners and the general public. Calls from news agencies or reporters were forwarded to the Governor's office through DPH's Office of Health Risk Communication. Better than half the constituents called or emailed to request application materials that were either mailed to their home or attached to an email. The webpage had approximately 11,000 hits for the year, averaging about 930 hits per month. Please refer to Appendix B on page 9 of this report for graphical representation of the constituent initiated correspondence.

Registry Card Program Participation Analysis

During fiscal year 2013, 55 applications for registry cards were filed with OMM; eight for caregivers and 47 for patients. At the end of the reporting period, the status of those 55 applications were as follows: seven were incomplete, five were withdrawn by the patient, four were denied by the department, one was approved but not yet issued, one was in review, and 38 cards were issued to cardholders but one was returned to OMM. The patient who returned the card withdrew from the program due to subsequent concern regarding the legal ramifications of participating in the program with children in the house. This one card is counted in the withdrawn numbers. Appendix C on page 10 contains a table with these numbers as well as a few pie charts that break down the active cardholders by age, county, gender, and the debilitating medical conditions that qualified each active patient for the program.

The majority of registered patients qualified because of severe, debilitating pain or severe, persistent muscle spasms, but there are several who have cancer and a handful of other debilitating conditions as noted in the chart in Appendix C on page 10. Also, the majority of cardholders live in New Castle County, 23 patients and the one caregiver that is registered. Sussex has the next highest and Kent last, nine and four respectively. Thirty-four physicians have participated in the program by completing and signing the physician's certification form for their patients. Seven of these doctors have certified more than one of their patients for the card program. Most of those physicians have offices in New Castle County, with only 18% of them in Sussex and just 12% in Kent.

IV. Interagency Coordination

In response to the Act, a verification system was established to allow 24 hours a day and 7 days a week access to law enforcement officials with the purpose of being able to check the accuracy and status of a

card holder. With that goal in mind, senior HSP staff revitalized a working relationship with the Delaware Criminal Justice Information System (DELJIS). On March 14, 2012, OMM staff met with management and key staff in the DELJIS office to discuss the requirements for law enforcement access to the program's data. The meeting initiated the development of additional screens programmed for the DELJIS system. OMM staff were trained and given access to DELJIS for the purpose of entering MMP card holder data. Since law enforcement already has access to the DELJIS system, they will easily be able to validate a card holder's registration any time of day, as needed. After the initiation of the plan, OMM worked over the next six months with the DELJIS staff to define the required data fields and test the developed screens.

Also required by the Act is a multi-jurisdictional background check for caregiver applicants. To accomplish this goal, DPH reached out again for coordination with another state agency. The State Bureau of Identification helped OMM staff to understand the procedures for applicants to apply for a state background check. The SBI also pointed program staff in the direction of the FBI for understanding the process of the application for a national background check. Both of these processes are initiated by the caregiver applicant, and the results can either be sent to the caregiver applicant, and then mailed to OMM, or sent directly to the OMM for inclusion in the application file prior to review and approval. The form that is submitted to SBI by the caregiver to request fingerprints and a state background check is included in Appendix D. The online, fillable FBI background summary check form is completed, printed, signed, and mailed, along with the fingerprints the caregiver obtained from SBI and the required fee, to the FBI. The requested results are mailed in about five to six weeks after they are received by the FBI.

Finally, the Division of Motor Vehicles (DMV) provided training to program staff in the realm of identifying legitimate and counterfeit identification documents such as state-issued identification cards and birth certificates, both of which are required by law to be verified for applicants to the MMP.

V. DPH Initiatives

Creating an understanding of the MMP's direction and focus will be a top priority in the coming months as we prepare for the governor's lifting of the suspension on the compassion centers. The Division will reach out to the various stakeholders involved in, or affected by, Delaware's MMP. These groups include, but are not limited to, the medical community through open communication with the Delaware Medical Society and the general public through correspondence with media venues and advocacy groups. Additionally, we look forward to having discussions with various avenues and departments of law enforcement, such as the State Police, the Delaware Police Chief's Association, Probation and Parole agencies, the Fraternal Order of Police (FOP), Alcohol and Tobacco Enforcement agencies, and local police departments like Wilmington and New Castle County.

The key to the safety of the MMP is product testing for both contaminates and potency. There will be a concerted effort to define what testing is required to ensure a balance between product safety and the cost effectiveness.

Diversion of medical marijuana to unauthorized recipients is the most difficult challenge the program faces. Compassion centers and the Department will work together to address the issue of diversion through pattern of consumption and vigilance.

Growth of the program and authorized patient access to purchase medical marijuana must be balanced against the concerns of the Federal Government when deciding the number, size and location of compassion centers. The program will work with all stakeholders and the nine-member oversight committee called for in the Act to strive for an appropriate balance.

Appendix A. Poverty Guidelines for Adjusted Application Fee

Return to Compliance Activities

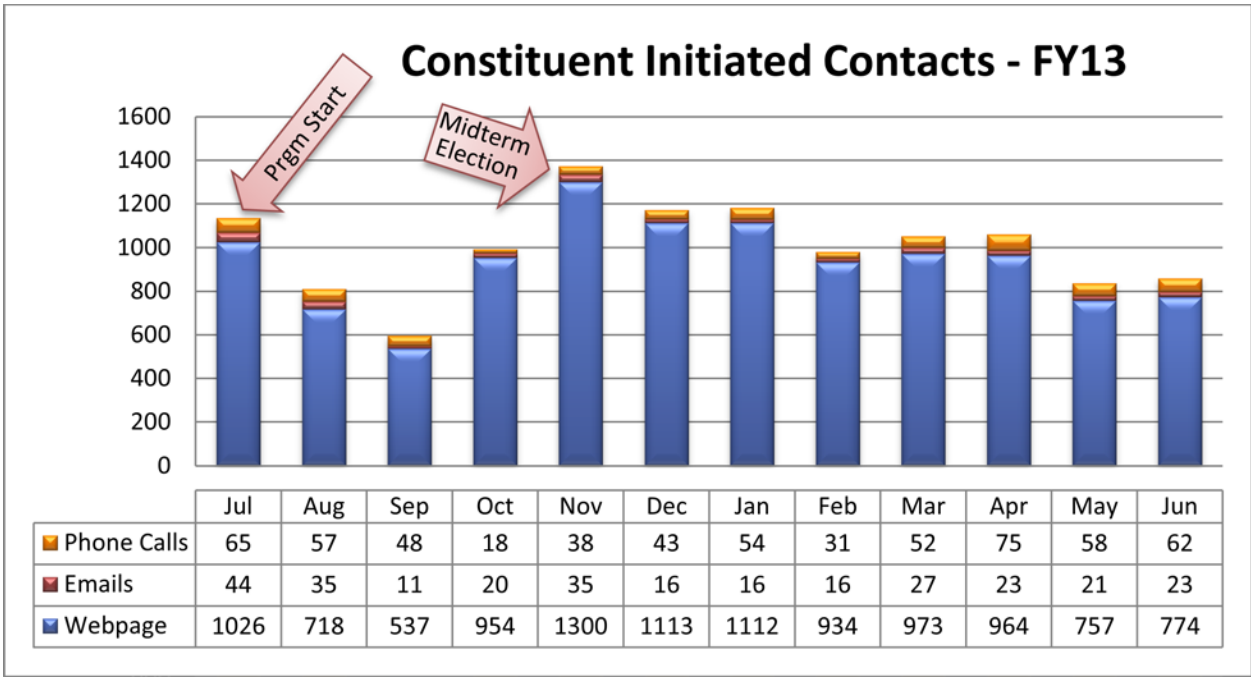
2012 Poverty Guidelines Set by the Federal Government							
Gross Annual Household Income up to the following % of Federal Poverty Level							
Size of Household	100%	230%	245%	260%	275%	290%	More
1	$11,170	$25,691	27,367	$29,042	$30,718	$32,393	$32,393
2	$15,130	$34,799	37,069	$39,338	$41,608	$43,877	$43,877
3	$19,090	$43,907	46,771	$49,634	$52,498	$55,361	$55,361
4	$23,050	$53,015	56,473	$59,930	$63,388	$66,845	$66,845
5	$27,010	$62,123	66,175	$70,226	$74,278	$78,329	$78,329
6	$30,970	$71,231	75,877	$80,522	$85,168	$89,813	$89,813
7	$34,930	$80,339	85,579	$90,818	$96,058	$101,297	$101,297
8	$38,890	$89,447	95,281	$101,114	$106,948	$112,781	$112,781
9	$42,850	$98,555	104,983	$111,410	$117,838	$124,265	$124,265
10	$46,810	$107,663	114,685	$121,706	$128,728	$135,749	$135,749
% charges to be paid	0%	0%	20% or $25	40% or $50	60% or $75	80% or $100	100% or $125

Table A-1: Sliding scale used to adjust application fee based on applicant's income as proven by submitted documentation. This scale was used for applications submitted prior to April 1, 2013.

2013 Poverty Guidelines Set by the Federal Government							
Gross Annual Household Income up to the following % of Federal Poverty Level							
Size of Household	100%	230%	245%	260%	275%	290%	More
1	$11,490	$26,427	$28,151	$29,874	$31,598	$33,321	$33,321
2	$15,510	$35,673	$38,000	$40,326	$42,653	$44,979	$44,979
3	$19,530	$44,919	$47,849	$50,778	$53,708	$56,637	$56,637
4	$23,550	$54,165	$57,698	$61,230	$64,763	$68,295	$68,295
5	$27,570	$63,411	$67,547	$71,682	$75,818	$79,953	$79,953
6	$31,590	$72,657	$77,396	$82,134	$86,873	$91,611	$91,611
7	$35,610	$81,903	$87,245	$92,586	$97,928	$103,269	$103,269
8	$39,630	$91,149	$97,094	$103,038	$108,983	$114,927	$114,927
9	$43,650	$100,395	$106,943	$113,490	$120,038	$126,585	$126,585
10	$47,670	$109,641	$116,792	$123,942	$131,093	$138,243	$138,243
% charges to be paid	0%	0%	20% or $25	40% or $50	60% or $75	80% or $100	100% or $125

Table A-2: Sliding scale used to adjust application fee based on applicant's income as proven by submitted documentation. This scale was used for applications submitted after April 1, 2013.

Appendix B. Constituent Correspondence Analysis



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Phone Calls	65	57	48	18	38	43	54	31	52	75	58	62
Emails	44	35	11	20	35	16	16	16	27	23	21	23
Webpage	1026	718	537	954	1300	1113	1112	934	973	964	757	774

Chart B-1: Total number of incoming correspondence to OMM during SFY 2013.

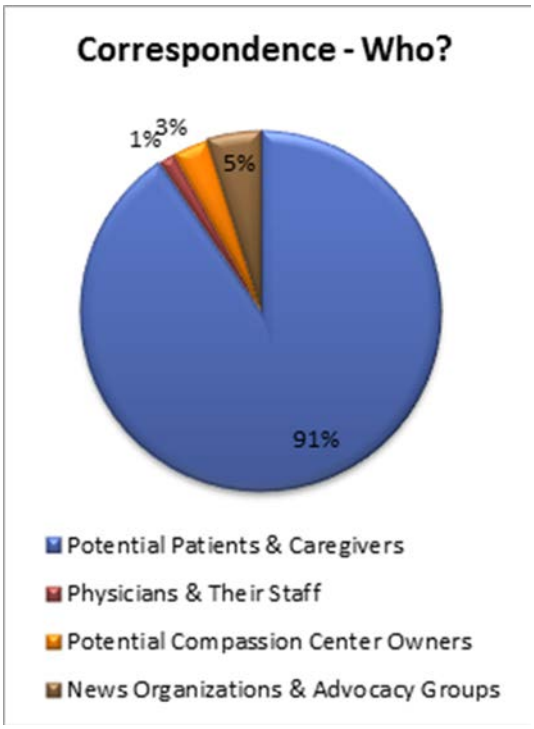


Chart B-2: For emails & calls in FY '13; does not include webpage hits. What was the roll of the contact person?

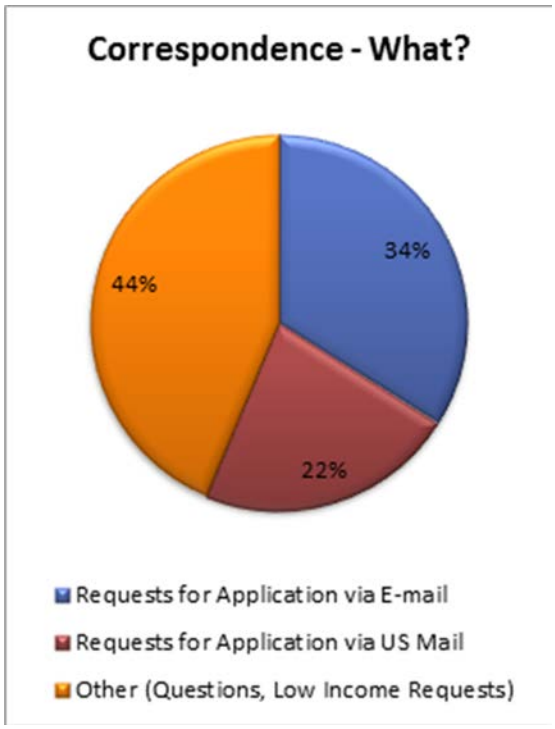


Chart B-3: For emails & calls in FY '13; does not include webpage hits. What was the purpose of the call?

Appendix C. Program Participation Analysis

Status	Patients	Caregivers	Totals
Incomplete	4	3	**7**
Withdrawn	1	4	**5**
In Review	1	0	**1**
Approved	1	0	**1**
Denied	4	0	**4**
Issued	36	1	**37**
Total	**47**	**8**	**55**

Table C-1: Total applications received by OMM in SFY 2013.

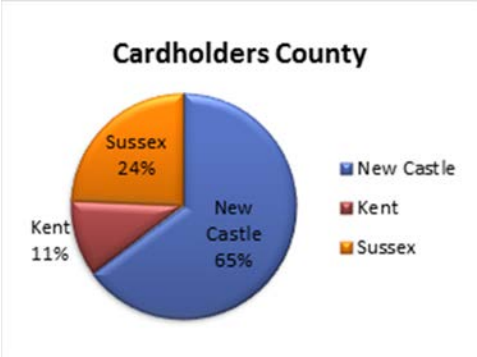


Chart C-1: Active card holders by county.

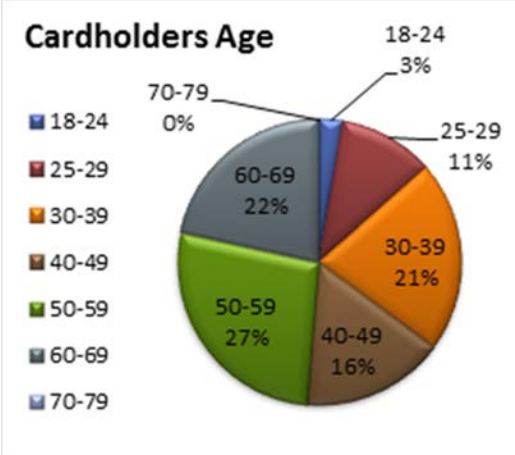


Chart C-2: Active card holders by age.

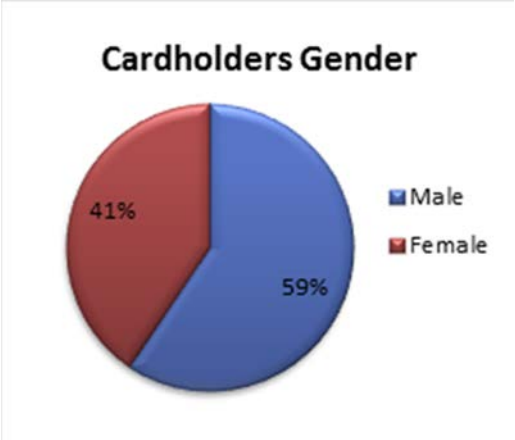


Chart C-3: Active card holders by gender.

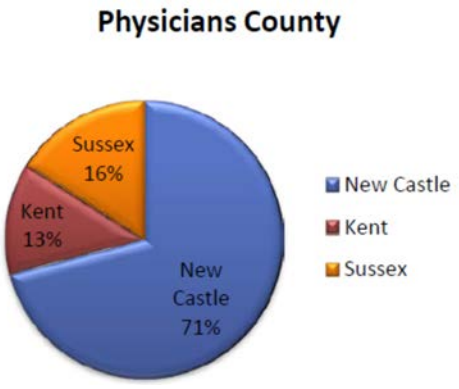


Chart C-4: Certifying physicians by county.

Patients	Condition	Patients	Condition
5	Cancer	1	ALS or Lou Gehrig's Disease
1	HIV Positive	1	Cachexia or wasting syndrome
0	AIDS	15	Severe, debilitating pain
0	Hepatitis C	2	Intractable nausea
0	PTSD	11	Severe, persistent muscle spasms
1	Seizures	0	Alzheimer's disease
1	Caregiver		

Table C-2: Qualifying patients with active registration cards by debilitating medical condition.

Appendix D. Registry Card Application Forms

Patient Application (Return to Program Development)

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

DPH/HSP office use only
Date Received _____ Issue Date _____
Staff Initials _____ Expiration Date _____
☐ Approved ☐ Denied App/Den Date _____

Please print clearly. Incomplete applications will be denied. Denied applicants are required to wait six months before applying again with another application fee. Please put "N/A" if not applicable. Application fees are non-refundable. **Faxed and electronic copies will not be accepted.**

Patient Application

☐ New Patient ☐ Renewing Patient Current Registry ID Card # _____

CONTACT INFORMATION

Date of birth _____ Gender ☐ Male ☐ Female
Must be at least 18 mm / dd / yyyy

Name _____
Title First Middle initial Last Suffix(es)

(This name must match the name on your State Issued Photo ID or Driver's License.)

Residence address The address provided below must be your physical residence and will appear on your registry card.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____

Mailing address ☐ Check if mailing address is the same as residential.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____

Primary phone number _____ Type of phone (home, cell) _____
Secondary number _____ Type of phone (home, cell) _____

E-mail address _____
Note regarding E-mail: Please note that confidential and time sensitive information will be sent to this e-mail address. Failure to respond to e-mails may result in your application being delayed, withdrawn or denied. It is the applicant's responsibility to add MedicalMarijuanaDPH@state.de.us to their list of safe senders to avoid having messages sent to their junk e-mail folder. Instructions on how to add an e-mail address to your list of safe senders can be found in your e-mail provider's documentation. ***It is not required that you submit your e-mail address***.

PHYSICIAN INFORMATION

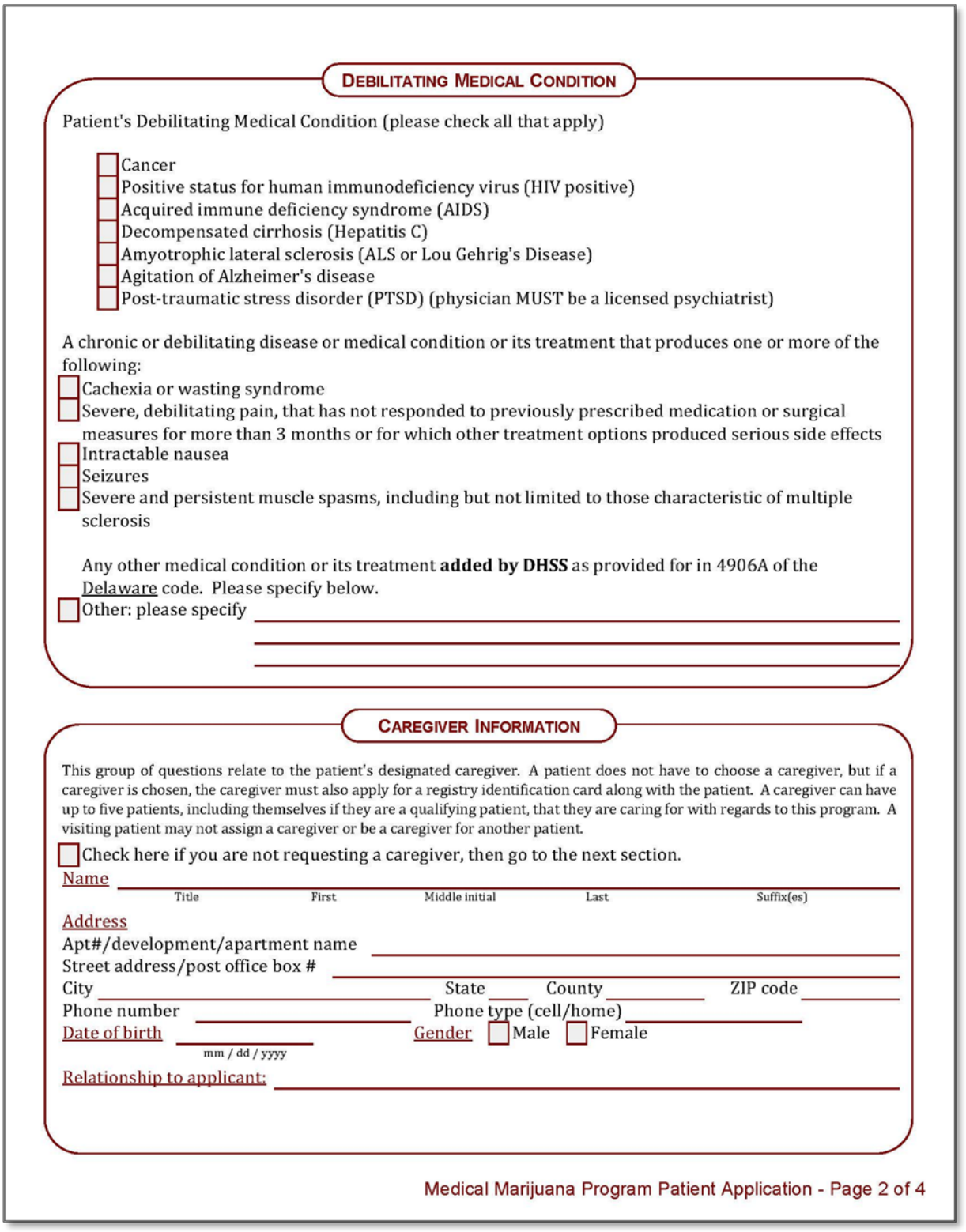
The following information relates to the patient's physician who completes the Physician Certification form. If the qualifying patient's debilitating medical condition is Post-Traumatic Stress Disorder, the physician must also be a licensed psychiatrist. This information should be provided by the physician on the Physician Certification form and can be copied from there.

Name _____
Title First Middle initial Last Suffix(es)

Practice/group name (if applicable) _____
Address (suite/room number, etc.) _____
Number & street _____
City, state, & zip _____
Phone number _____ Fax number _____
License number _____ License state ____ License type _____
Length of time the patient has been under the care of this Physician (years &/or months) _____

417 FEDERAL STREET • JESSE COOPER BUILDING, SUITE 205 DOVER DELAWARE 19901
(302) 744-4749 • MEDICALMARIJUANADPH@STATE.DE.US

Figure D-1: Patient Applications for patient a registry card (page one).



DEBILITATING MEDICAL CONDITION

Patient's Debilitating Medical Condition (please check all that apply)

- ☐ Cancer
- ☐ Positive status for human immunodeficiency virus (HIV positive)
- ☐ Acquired immune deficiency syndrome (AIDS)
- ☐ Decompensated cirrhosis (Hepatitis C)
- ☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- ☐ Agitation of Alzheimer's disease
- ☐ Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist)

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects
- ☐ Intractable nausea
- ☐ Seizures
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis

Any other medical condition or its treatment **added by DHSS** as provided for in 4906A of the Delaware code. Please specify below.

☐ Other: please specify _____

CAREGIVER INFORMATION

This group of questions relate to the patient's designated caregiver. A patient does not have to choose a caregiver, but if a caregiver is chosen, the caregiver must also apply for a registry identification card along with the patient. A caregiver can have up to five patients, including themselves if they are a qualifying patient, that they are caring for with regards to this program. A visiting patient may not assign a caregiver or be a caregiver for another patient.

☐ Check here if you are not requesting a caregiver, then go to the next section.

Name _____
Title First Middle initial Last Suffix(es)

Address
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____
Phone number _____ Phone type (cell/home) _____
Date of birth _____ Gender ☐ Male ☐ Female
mm / dd / yyyy

Relationship to applicant: _____

Medical Marijuana Program Patient Application - Page 2 of 4

Figure D-2: Patient Applications for a patient registry card (page two).

VOLUNTARY DEMOGRAPHIC INFORMATION

Please 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 of our 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. Your voluntary answers are requested. Thank you.

Marital Status

What is your current marital status?

a. __ Single b. __ Married/Civil Union c. __ Divorced
d. __ Separated e. __ Widowed f. __ Unmarried partnership

Ethnicity

Which of the following best describes your ethnicity?

a. __ Hispanic or Latino b. __ Non-Hispanic or Latino

Race

Which of the following best describes your racial heritage?

a. __ Caucasian/White d. __ African American/Black
b. __ Asian e. __ American Indian or Alaska native
c. __ Native Hawaiian or pacific islander f. __ Other

Language

How well do you speak English?

a. __ Very well b. __ Well c. __ Not well d. __ Not at all

Do you speak a language other than English at home?

a. __ No b. __ Yes, Spanish c. __ Yes, not Spanish, please specify: _____

Veteran Status

Are you a United States veteran?

a. __ Yes b. __ No

Citizenship

Are you a citizen or lawful resident of the United States of America? a. __ Yes b. __ No

Education

What is your highest level of education completed?

a. __ High school last grade completed d. __ Technical school
b. __ High school diploma/GED e. __ University or 4-year college
c. __ Community college/2-year degree f. __ Master program or above

Are you currently enrolled in school?

a. __ No b. __ Yes If yes, what level? _____

Employment

Are you currently working? a. __ No b. __ Part Time c. __ Full Time

What is your occupation? _____

Income

What is your annual household income?

a. __ Less than $20,000 d. __ $60,000 to $79,999
b. __ $20,000 to $39,999 e. __ $80,000 to $99,999
c. __ $40,000 to $59,999 f. __ $100,000 or above

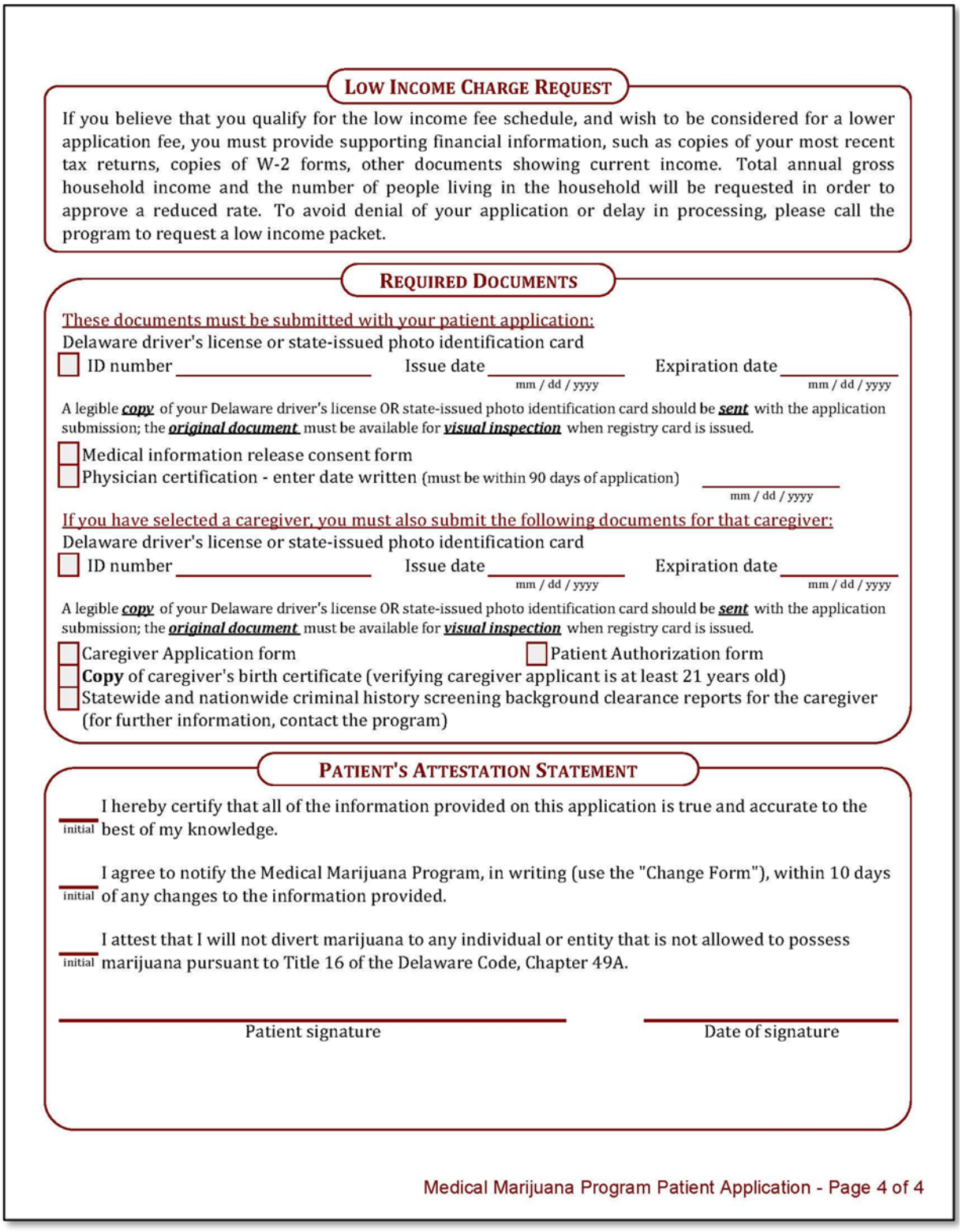
Public Assistance

Are you currently enrolled in a public assistance program such as the DE food supplement program, health insurance, child care assistance, energy assistance program, or any other public assistance program?

a. __ No b. __ Yes Which program(s)? _____

Medical Marijuana Program Patient Application - Page 3 of 4

Figure D-3: Patient Application required for a patient registry card (page three).



Low Income Charge Request

If you believe that you qualify for the low income fee schedule, and wish to be considered for a lower application fee, you must provide supporting financial information, such as copies of your most recent tax returns, copies of W-2 forms, other documents showing current income. Total annual gross household income and the number of people living in the household will be requested in order to approve a reduced rate. To avoid denial of your application or delay in processing, please call the program to request a low income packet.

Required Documents

These documents must be submitted with your patient application:

Delaware driver's license or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Medical information release consent form

☐ Physician certification - enter date written (must be within 90 days of application) _____ (mm / dd / yyyy)

If you have selected a caregiver, you must also submit the following documents for that caregiver:

Delaware driver's license or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Caregiver Application form ☐ Patient Authorization form

☐ **Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)

☐ Statewide and nationwide criminal history screening background clearance reports for the caregiver (for further information, contact the program)

Patient's Attestation Statement

_____ (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 (use the "Change Form"), 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.

_____ Patient signature

_____ Date of signature

Medical Marijuana Program Patient Application - Page 4 of 4

Figure D-4: Patient Application required for a patient registry card (page four).

Physician Certification (Return to Program Development)

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

DPH/HSP office use only

Date received _____ Staff initials _____ Date verified _____ Staff initials _____

Physician verified in good standing? ☐ Yes ☐ No

Please print clearly and answer all of the questions. Patients, please have your physician complete the entire form. This form should be submitted with your Application to the Medical Marijuana Program at the address on the first page of application instructions. **Faxed and electronic copies will not be accepted. NOTE: This does NOT constitute a prescription for marijuana. The patient's application for the medical marijuana program must be received by DPH within 90 days of the signature date on this form.**

Physician Certification

Patient Information

Physician instructions: please complete this section with the information in the patient's record.

Name _____
Title First Middle initial Last Suffix(es)

Patient's address
Apt#/development/apartment name _____
Number & street _____
City _____ State ____ County _____ ZIP code _____
Patient's date of birth _____ Patient's phone number _____
mm / dd / yyyy

Debilitating Medical Condition

These are the ONLY qualifying debilitating medical conditions. Check all that apply to this patient.

- ☐ Cancer
- ☐ Positive status for human immunodeficiency virus (HIV positive)
- ☐ Acquired immune deficiency syndrome (AIDS)
- ☐ Decompensated cirrhosis (Hepatitis C)
- ☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- ☐ Agitation of Alzheimer's disease
- ☐ Post-traumatic stress disorder (PTSD) (physician MUST be a licensed psychiatrist)

A chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following:

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating pain, that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects
- ☐ Intractable nausea
- ☐ Seizures
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis

Any other medical condition or its treatment **added by DHSS** as provided for in 4906A of the Delaware code. Please specify below.

- ☐ Other: please specify _____

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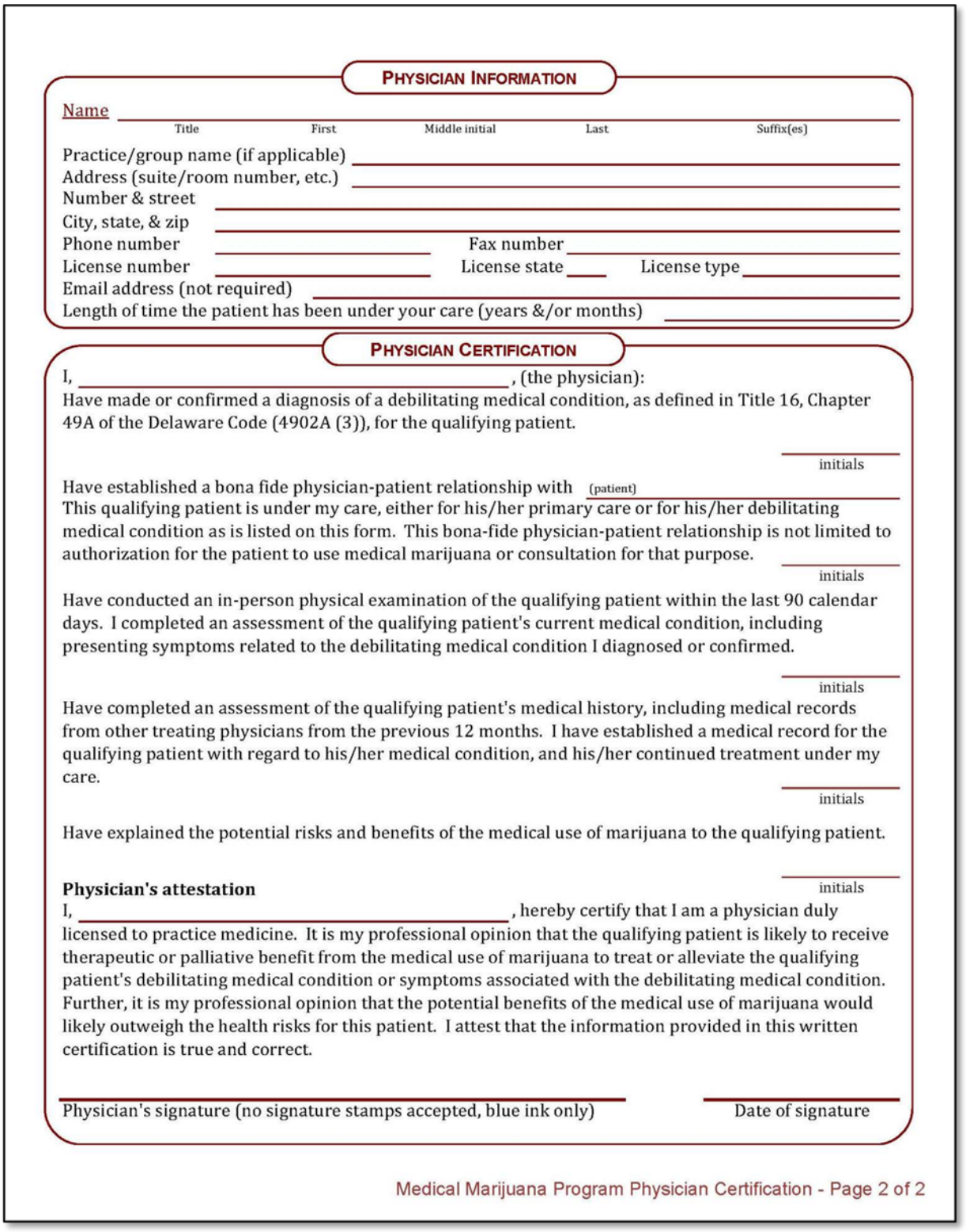
Figure D-5: Physician Certification required for a patient registry card (page one).



PHYSICIAN INFORMATION

Name _____
Title First Middle initial Last Suffix(es)

Practice/group name (if applicable) _____
Address (suite/room number, etc.) _____
Number & street _____
City, state, & zip _____
Phone number _____ Fax number _____
License number _____ License state ____ License type _____
Email address (not required) _____
Length of time the patient has been under your care (years &/or months) _____

PHYSICIAN CERTIFICATION

I, _____, (the physician):
Have made or confirmed a diagnosis of a debilitating medical condition, as defined in Title 16, Chapter 49A of the Delaware Code (4902A (3)), for the qualifying patient.

_____ initials

Have established a bona fide physician-patient relationship with (patient) _____
This qualifying patient is under my care, either for his/her primary care or for his/her debilitating medical condition as is listed on this form. This bona-fide physician-patient relationship is not limited to authorization for the patient to use medical marijuana or consultation for that purpose. _____ initials

Have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. 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.

_____ initials

Have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient with regard to his/her medical condition, and his/her continued treatment under my care.

_____ initials

Have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient.

_____ initials

Physician's attestation

I, _____, 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 qualifying patient's 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 provided in this written certification is true and correct.

_____ _____
Physician's signature (no signature stamps accepted, blue ink only) Date of signature

Medical Marijuana Program Physician Certification - Page 2 of 2

Figure D-6: Physician Certification required for a patient registry card (page two).

Release of Medical Information (Return to Program Development)

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

DPH/HSP office use only
Date received _____ Patient verified with certifying physician?
Staff initials _____ ☐ Yes ☐ No
Date verified _____
Staff initials _____

Patients, please complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician relating to your 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.**

Release of Medical Information Form

PATIENT RELEASE REQUEST

I, _____, (patient's name):
hereby authorize the Delaware Department of Health and Social Services, Medical Marijuana Program to discuss my medical condition, including treatment records, test results, and evaluations specific to _____ (the patient's qualifying condition)
with my certifying medical provider (print certifying medical provider's name below)
(Physician's first name:) _____ Last name: _____
and, if applying under **post-traumatic stress disorder**, my licensed psychiatrist
(Psychiatrist's first name:) _____ Last 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 Medical Marijuana Program, and that revocation may result in the inability of the program to certify me as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to 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 eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my 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 in one (1) year unless a different expiration date prior to one year is specified here: / / .

_____ _____
Patient's signature Date of signature

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Figure D-7: Release of medical information form required for patient registration card.

Caregiver Application (Return to Program Development)

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

DPH/HSP office use only
Date received _____ Issue date _____
Staff initials _____ Expiration date _____
☐ Approved ☐ Denied App/den date _____

Please print clearly. Caregivers must be Delaware state residents and have a state-issued driver's license or identification card. Incomplete applications will be denied. Caregiver applications are only accepted as a supplement to a patient's application. Please put "N/A" if not applicable. **Application fees are non-refundable. Faxed and electronic copies will not be accepted.**

Caregiver Application

☐ New caregiver ☐ Renewing caregiver Current Registry ID Card # _____

CONTACT INFORMATION

Date of birth _____ Gender ☐ Male ☐ Female
Must be at least 21 mm / dd / yyyy

Name _____
Title First Middle initial Last Suffix(es)

(This name must match the name on your state-issued photo identification or driver's license.)

Residence address The address provided below must be your physical residence and will appear on your registry card.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____

Mailing address ☐ Check if mailing address is the same as residential.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____

Primary phone number _____ Type of phone (home, cell) _____
Secondary number _____ Type of phone (home, cell) _____

E-mail address _____

Note regarding E-mail: Please note that confidential and time sensitive information will be sent to this e-mail address. Failure to respond to e-mails may result in your application being delayed, withdrawn or denied. It is the applicant's responsibility to add MedicalMarijuanaDPH@state.de.us to their list of safe senders to avoid having messages sent to their junk e-mail folder. Instructions on how to add an e-mail address to your list of safe senders can be found in your e-mail provider's documentation. ***It is not required that you submit your e-mail address***.

PATIENT INFORMATION

The following information relates to the patient. A caregiver must complete this Caregiver Application for each patient they wish to assist with the medical use of marijuana. The patient will then submit the form to the program for review. A caregiver may have up to five (5) patients including himself/ herself in the case that they are also a patient.

Name _____
Title First Middle initial Last Suffix(es)

Address
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State ____ County _____ ZIP code _____
Phone number _____ Phone type (cell/home) _____
Date of birth _____ (mm/dd/yyyy) Gender ☐ Male ☐ Female
Relationship to caregiver: _____
Patient's Medical Marijuana registry ID# if known: _____

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Figure D-8: Caregiver Application required for a caregiver registry card (page one).

APPLICANT DEMOGRAPHIC INFORMATION

It is the policy of the state of Delaware to assure equal and fair treatment in all aspects of healthcare for all of our 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. Your voluntary answers are requested. Thank you.

Marital Status
What is your current marital status?
a. __ Single b. __ Married/Civil Union c. __ Divorced
d. __ Separated e. __ Widowed f. __ Unmarried partnership

Ethnicity
Which of the following best describes your ethnicity?
a. __ Hispanic or Latino b. __ Non-Hispanic or Latino

Race
Which of the following best describes your racial heritage?
a. __ Caucasian/White d. __ African American/Black
b. __ Asian e. __ American Indian or Alaska native
c. __ Native Hawaiian or pacific islander f. __ Other

Language
How well do you speak English?
a. __ Very well b. __ Well c. __ Not well d. __ Not at all

Do you speak a language other than English at home?
a. __ No b. __ Yes, Spanish c. __ Yes, not Spanish, please specify: _____

Veteran Status
Are you a United States veteran?
a. __ Yes b. __ No

Citizenship
Are you a citizen or lawful alien of the United States of America? a. __ Yes b. __ No

Education
What is your highest level of education completed?
a. __ High school last grade completed d. __ Technical school
b. __ High school diploma/GED e. __ University or 4-year college
c. __ Community college/2-year degree f. __ Master program or above

Are you currently enrolled in school?
a. __ No b. __ Yes If yes, what level? _____

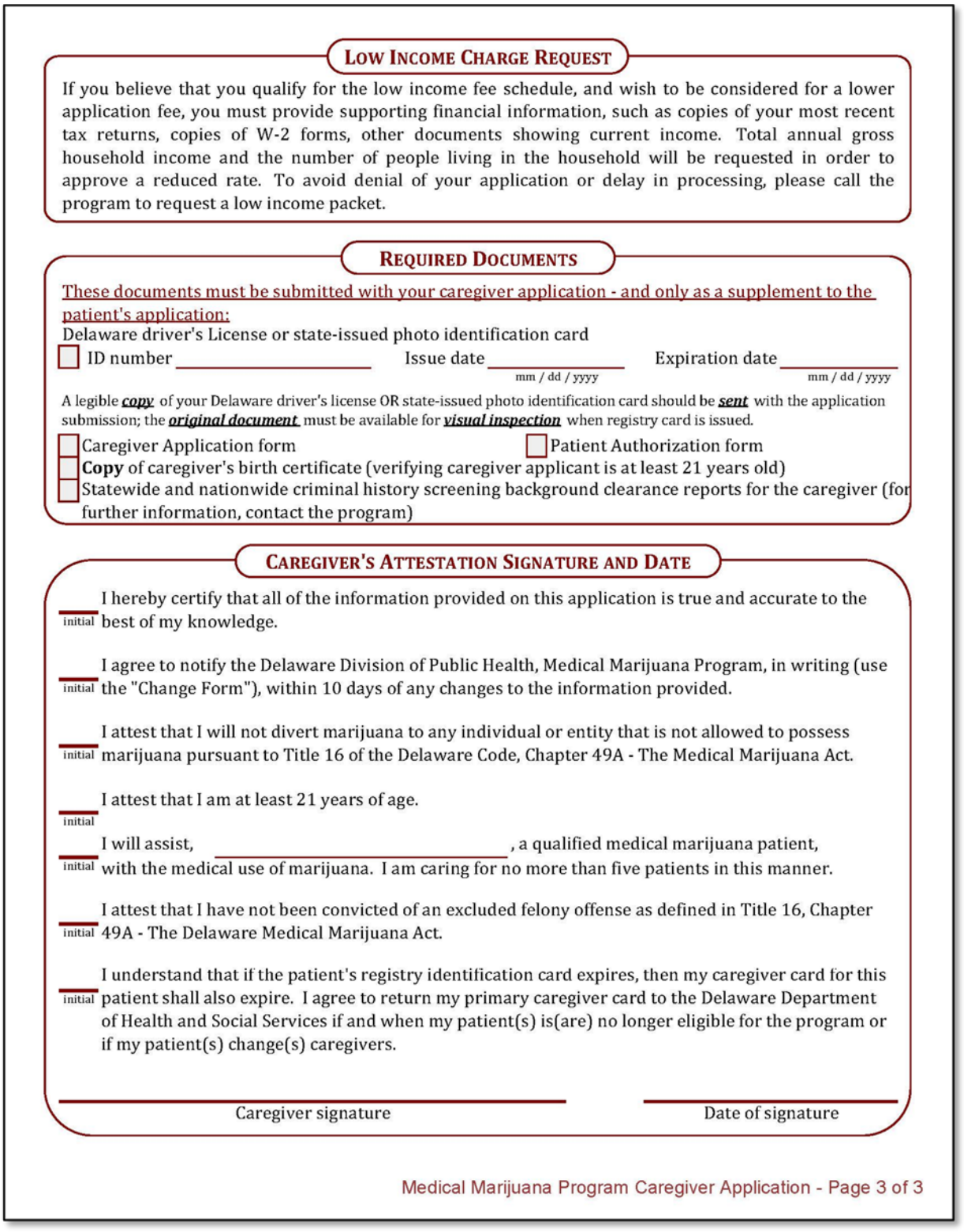
Employment
Are you currently working? a. __ No b. __ Part Time c. __ Full Time
What is your occupation? _____

Income
What is your annual household income?
a. __ Less than $20,000 d. __ $60,000 to $79,999
b. __ $20,000 to $39,999 e. __ $80,000 to $99,999
c. __ $40,000 to $59,999 f. __ $100,000 or above

Public Assistance
Are you currently enrolled in a public assistance program such as the DE food supplement program, health insurance, child care assistance, energy assistance program, or any other public assistance program?
a. __ No b. __ Yes Which program(s)? _____

Medical Marijuana Program Caregiver Application - Page 2 of 3

Figure D-9: Caregiver Application required for a caregiver registry card (page two).



Low Income Charge Request

If you believe that you qualify for the low income fee schedule, and wish to be considered for a lower application fee, you must provide supporting financial information, such as copies of your most recent tax returns, copies of W-2 forms, other documents showing current income. Total annual gross household income and the number of people living in the household will be requested in order to approve a reduced rate. To avoid denial of your application or delay in processing, please call the program to request a low income packet.

Required Documents

These documents must be submitted with your caregiver application - and only as a supplement to the patient's application:

Delaware driver's License or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Caregiver Application form ☐ Patient Authorization form
☐ **Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)
☐ Statewide and nationwide criminal history screening background clearance reports for the caregiver (for further information, contact the program)

Caregiver's Attestation Signature and Date

_____ 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 Delaware Division of Public Health, Medical Marijuana Program, in writing (use the "Change Form"), 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 - The Medical Marijuana Act.

_____ initial I attest that I am at least 21 years of age.

_____ initial I will assist, _____, a qualified medical marijuana patient, with the medical use of marijuana. I am caring for no more than five patients in this manner.

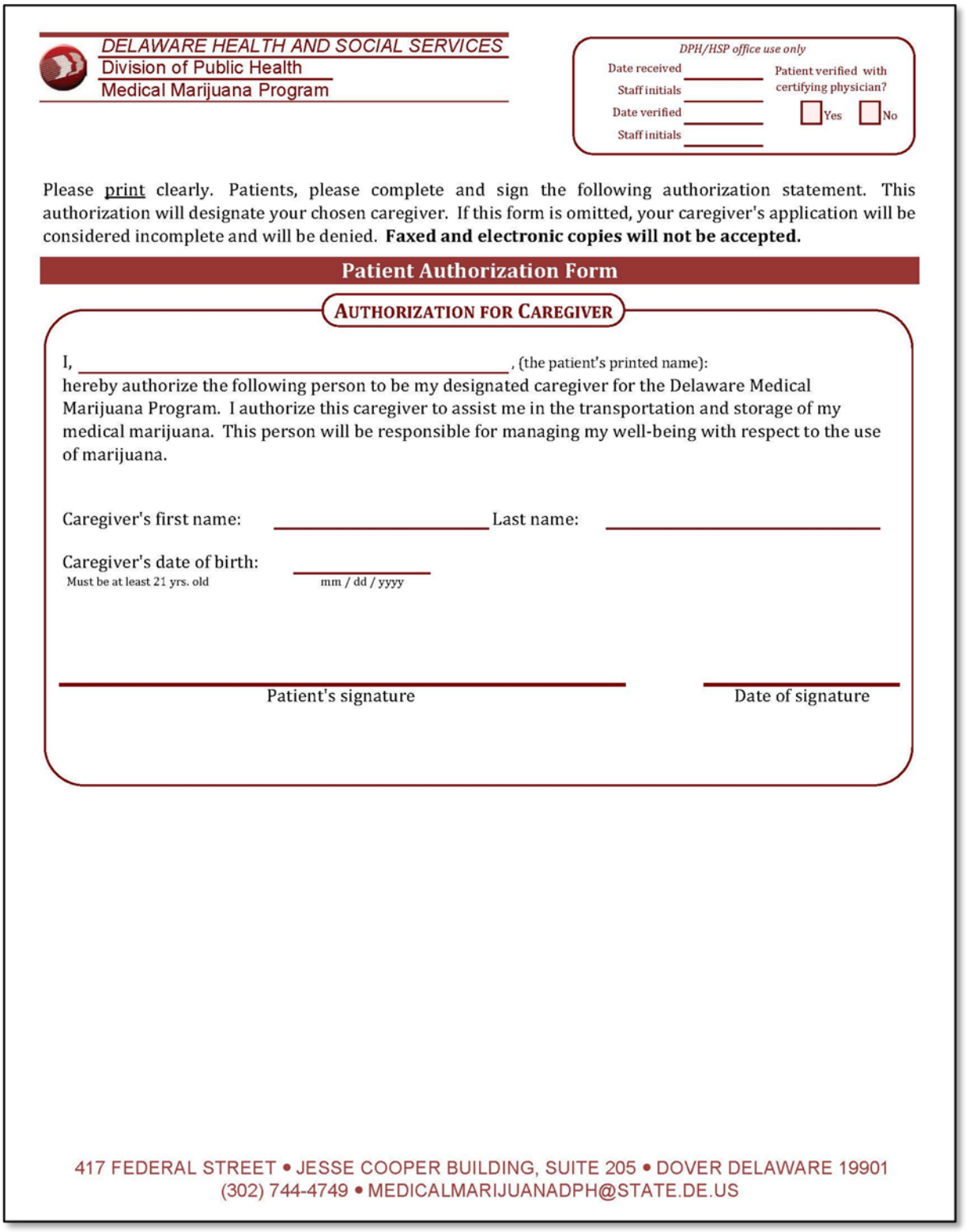
_____ initial I attest that I have not been convicted of an excluded felony offense as defined in Title 16, Chapter 49A - The Delaware Medical Marijuana Act.

_____ 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 Delaware Department of Health and Social Services 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

Medical Marijuana Program Caregiver Application - Page 3 of 3

Figure D-10 Caregiver Application required for a caregiver registry card (page three).



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

DPH/HSP office use only

Date received _____
Staff initials _____
Date verified _____
Staff initials _____

Patient verified with certifying physician? ☐ Yes ☐ No

Please print clearly. Patients, please complete and sign the following authorization statement. This authorization will designate your chosen caregiver. If this form is omitted, your caregiver's application will be considered incomplete and will be denied. **Faxed and electronic copies will not be accepted.**

Patient Authorization Form

AUTHORIZATION FOR CAREGIVER

I, _____, (the patient's printed name):
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 marijuana.

Caregiver's first name: _____ Last name: _____

Caregiver's date of birth: _____
Must be at least 21 yrs. old mm / dd / yyyy

_____ _____
Patient's signature Date of signature

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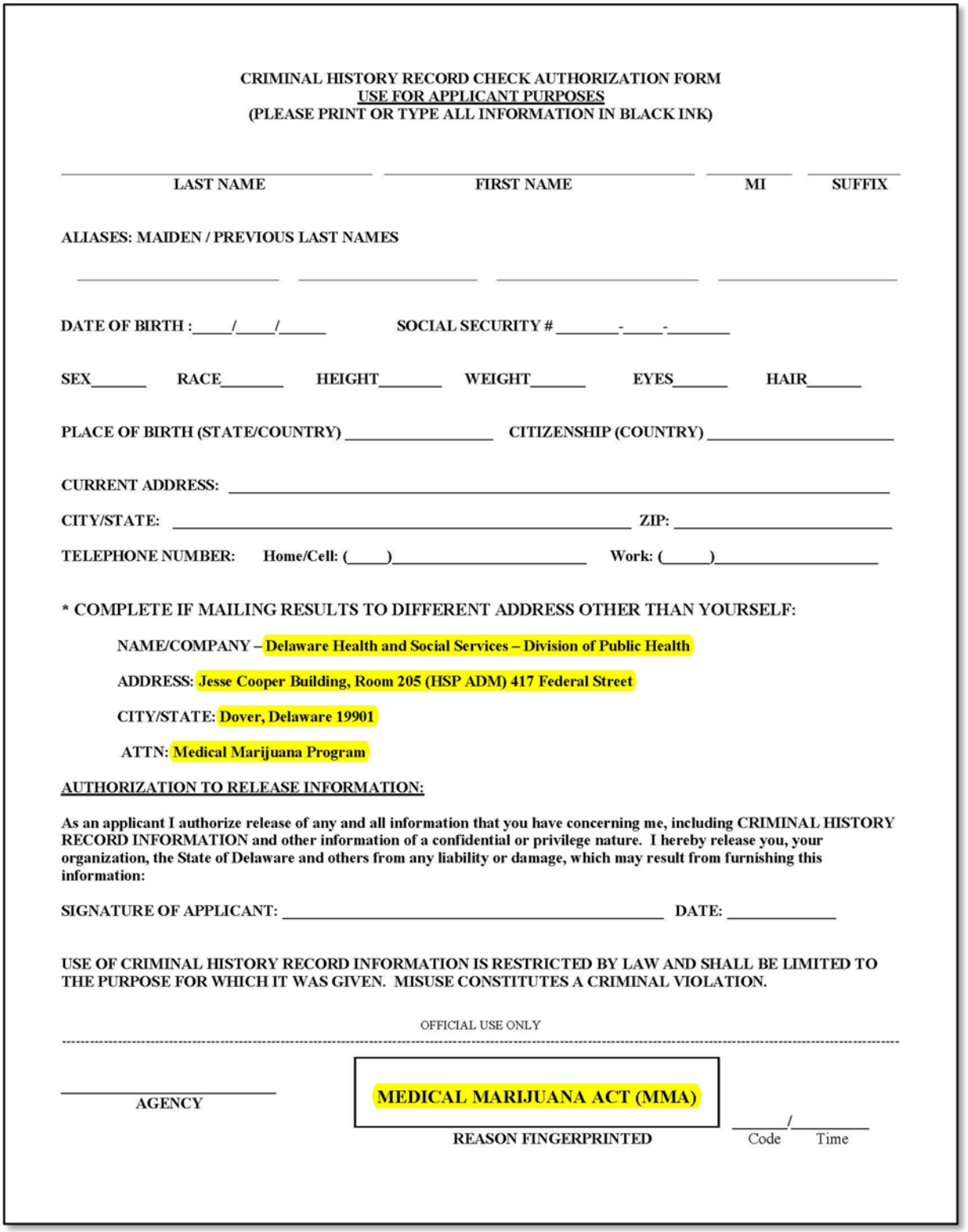
Figure D-11: Patient Authorization form required for a caregiver registry card.

Criminal Background Check Authorization Form (Return to Interagency Coordination)



CRIMINAL HISTORY RECORD CHECK AUTHORIZATION FORM
USE FOR APPLICANT PURPOSES
(PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK)

LAST NAME _____ FIRST NAME _____ MI _____ SUFFIX _____

ALIASES: MAIDEN / PREVIOUS LAST NAMES

_____ _____ _____ _____

DATE OF BIRTH :____/____/_____ SOCIAL SECURITY # _____-____-_____

SEX_____ RACE_____ HEIGHT_____ WEIGHT_____ EYES_____ HAIR_____

PLACE OF BIRTH (STATE/COUNTRY) _____ CITIZENSHIP (COUNTRY) _____

CURRENT ADDRESS: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE NUMBER: Home/Cell: (____)_____ Work: (____)_____

* COMPLETE IF MAILING RESULTS TO DIFFERENT ADDRESS OTHER THAN YOURSELF:

NAME/COMPANY – Delaware Health and Social Services – Division of Public Health

ADDRESS: Jesse Cooper Building, Room 205 (HSP ADM) 417 Federal Street

CITY/STATE: Dover, Delaware 19901

ATTN: Medical Marijuana Program

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant I authorize release of any and all information that you have concerning me, including CRIMINAL HISTORY RECORD INFORMATION and other information of a confidential or privilege nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage, which may result from furnishing this information:

SIGNATURE OF APPLICANT: _____ DATE: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

OFFICIAL USE ONLY

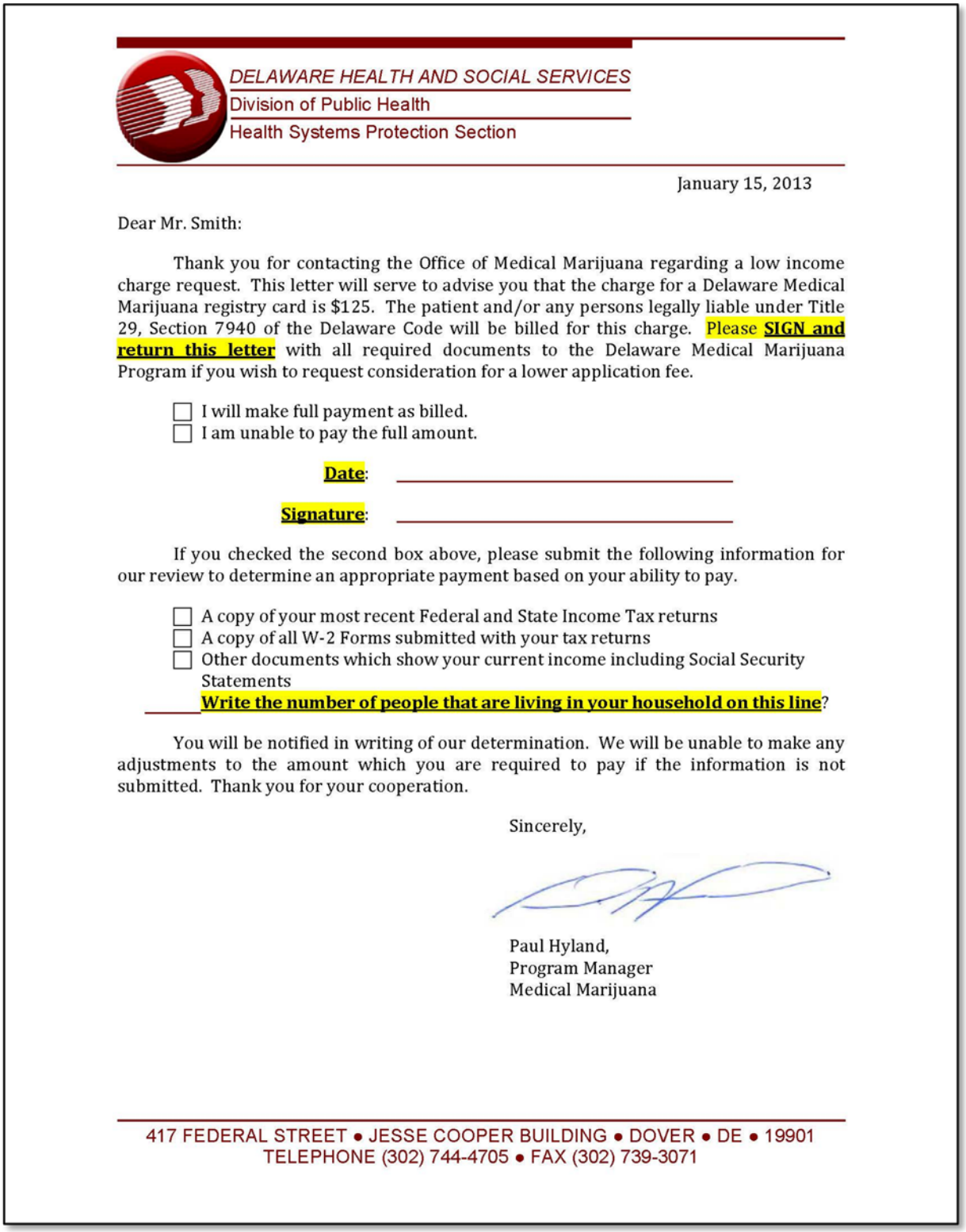
_____
AGENCY

MEDICAL MARIJUANA ACT (MMA)
REASON FINGERPRINTED

_____/_____
Code Time

Figure D-12: Criminal History Check Authorization Form required by SBI for fingerprinting.

Low Income Request Letter (Return to Program Development)



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Health Systems Protection Section

January 15, 2013

Dear Mr. Smith:

Thank you for contacting the Office of Medical Marijuana regarding a low income charge request. This letter will serve to advise you that the charge for a Delaware Medical Marijuana registry card is $125. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for this charge. Please **SIGN and return this letter** with all required documents to the Delaware Medical Marijuana Program if you wish to request consideration for a lower application fee.

☐ I will make full payment as billed.
☐ I am unable to pay the full amount.

Date: _____

Signature: _____

If you checked the second box above, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

☐ A copy of your most recent Federal and State Income Tax returns
☐ A copy of all W-2 Forms submitted with your tax returns
☐ Other documents which show your current income including Social Security Statements

_____ **Write the number of people that are living in your household on this line**?

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount which you are required to pay if the information is not submitted. Thank you for your cooperation.

Sincerely,

Paul Hyland,
Program Manager
Medical Marijuana

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TELEPHONE (302) 744-4705 • FAX (302) 739-3071

Figure D-13: Applicant request for an adjusted application fee due to low income.

Appendix E. Patient and Caregiver Registry Cards

(Return to Program Development)

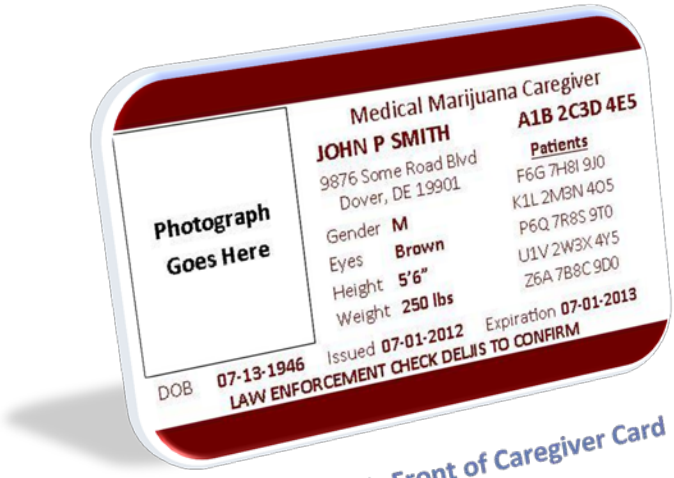

Figure E-1: Front of Caregiver Card

Figure E-2: Front of Patient Card

Figure E-3: Back of Both Cards